| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM  Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

## Filing at a Glance

Company: Starr Indemnity & Liability Company

| | | |
|---|---|---|
| Product Name: CV Starr STM  Ind | SERFF Tr Num: INCS-126474279 | State: Arkansas |
| TOI: H16I Individual Health - Major Medical | SERFF Status: Closed-Approved-Closed | State Tr Num: 44720 |
| Sub-TOI: H16I.004 Short Term | Co Tr Num: AH-60001 | State Status: Approved-Closed |
| Filing Type: Form/Rate | | Reviewer(s): Rosalind Minor |
| | Author: Renee Weaver | Disposition Date: 02/03/2010 |
| | Date Submitted: 01/28/2010 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

Project Name: CV Starr STM
Project Number: Ah-60001
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 02/03/2010

Deemer Date:
Submitted By: Renee Weaver
Filing Description:

Re: Star Indemnity & Liability Company
Individual Short Term Medical
 NAIC#:  38318 FEIN:  75-1670124
 H16I.004 Short Term

Enclosed Forms:
AH-60001-AR Policy Form

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Does not require prior approval
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 02/03/2010
Created By: Renee Weaver
Corresponding Filing Tracking Number:

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

AH-60008 Enrollment Form
AH-60008IR Reapplication Form
AH-60014I Waiver Rider
AH-60009IP Benefit Change Rider
AH-60001-AR-OOC Outline of Coverage

New Submission. This is a new submission. These forms are new and do not replace any of the Company's forms currently on file with your Department. Enclosed for your consideration is the Company's Individual Short Term Medical Insurance product.

These forms provide applicants and their dependents with medical coverage for a short term duration only. Their coverage period is 12-months or less and is non-renewable. As you know, the Health Insurance Portability and Accountability Act (HIPAA) specifically exempts short-term medical contracts from compliance with any HIPAA requirements.

Applicants will elect coverage using the Enrollment Form. They can elect another coverage period using the Reapplication Form. If they reapply, a new policy will be issued. If the company elects to waiver the pre-existing limitation for those who reapply, the Waiver Rider will be issued.

Variable Material. Variable material is shown in brackets. Changes made in a variable area of a Policy after it has been issued will be done via the Benefit Change Rider. Please note that this document will be used ONLY to make changes to variable areas of the forms that have already been issued. They will NOT be used to introduce new benefits or text that has not been filed with your Department. It will only be used as the form to make changes to a Policy that has already been issued so a new Policy does not need to be issued if a change is made while that Policy is effective.

Variable text will never exclude or limit provisions required by your state. Generally, any provision in brackets may be included or may be removed in accordance with the plan options offered. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary.

A detailed explanation of the variable text has been provided.

Filing Authority. This filing is being made by Innovative Compliance Solutions, LLC on behalf of the Company. A letter of filing authorization is attached.

Please note the following information:
1. The company's state of domicile is Texas and does not require prior filing or approval.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

2. Sale of the product will be through properly licensed agents.
3. Forms are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less that that required by your state. We would like to reserve the option of using the form in its submitted format electronically.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction. Should you have any questions, or need additional information, please contact me by email at rweaver@innovative-compliance.com or by telephone at 763-323-8643. My fax number is 763-712-8001.

Sincerely,

Renee Weaver
Compliance Consultant

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Renee Weaver, Consultant | rweaver@innovative-compliance.com |
| PO Box 773 | 763-323-8643 [Phone] |
| Anoka, MN 55303 | 763-712-8001 [FAX] |

**Filing Company Information**

(This filing was made by a third party - innovativecompliancesolutions)

| | | |
|---|---|---|
| Starr Indemnity & Liability Company | CoCode: 38318 | State of Domicile: Texas |
| 90 Park Avenue | Group Code: | Company Type: |
| 6th Floor | Group Name: | State ID Number: |
| New York, NY 10016 | FEIN Number: 75-1670124 | |
| (646) 227-6342 ext. [Phone] | | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | No |
| Fee Explanation: | $50 per filing |
| Per Company: | No |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM  Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Starr Indemnity & Liability Company | $50.00 | 01/28/2010 | 33861536 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 02/03/2010 | 02/03/2010 |

### Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---|---|---|---|---|---|---|
| **Status** | **Created By** | **Created On** | **Date Submitted** | **Responded By** | **Created On** | **Date Submitted** |
| Pending Industry Response | Rosalind Minor | 02/01/2010 | 02/01/2010 | Renee Weaver | 02/02/2010 | 02/02/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
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| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM  Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

# Disposition

Disposition Date: 02/03/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | Yes |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | Authorization Letter | Approved-Closed | Yes |
| **Supporting Document** | Explanation of Variables | Approved-Closed | Yes |
| **Form** | POLICY | Approved-Closed | Yes |
| **Form** | POLICY | Replaced | Yes |
| **Form** | APPLICATION | Approved-Closed | Yes |
| **Form** | RE-APPLICATION | Approved-Closed | Yes |
| **Form** | BENEFIT CHANGE ENDORSEMENT | Approved-Closed | Yes |
| **Form** | WAIVER OF PRE-X ENDORSEMENT | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

## Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 02/01/2010 |
| Submitted Date | 02/01/2010 |
| Respond By Date | |

Dear Renee Weaver,

This will acknowledge receipt of the captioned filing.

Objection 1

- POLICY, AH-60001-AR (Form)

Comment:

The Notice on the bottom of page 1 must comply with our Bulletin 15-2009. The address and phone number for the Arkansas Insurance Department is incorrect.

Objection 2

- POLICY, AH-60001-AR (Form)

Comment:

As a reminder, Arkansas does not allow Binding Arbitration. Please refer to ACA 23-79-203.

Objection 3

- POLICY, AH-60001-AR (Form)

Comment:

Under Premium Changes, there is a statement that says that the premium rates will not be changed more often than once every (6) months after the first policy anniversary.

It has been our Departmental policy for years that after the first annual anniversary of a policy, premiums will not be changed more than once in a twelve (12) month period.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 02/02/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

Submitted Date 02/02/2010

Dear Rosalind Minor,

**Comments:**
Thank you for your quick review! I've addressed your concerns below.

## Response 1

Comments: The address and phone number have been updated.

**Related Objection 1**

Applies To:

- POLICY, AH-60001-AR (Form)

Comment:

The Notice on the bottom of page 1 must comply with our Bulletin 15-2009. The address and phone number for the Arkansas Insurance Department is incorrect.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|---|---|---|---|---|---|---|
| *POLICY* | *AH-60001-AR* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | *43.100* | AH-60001-AR Ind STM Policy 2-10.pdf |
| ***Previous Version*** | | | | | | | |
| *POLICY* | *AH-60001-AR* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | *43.100* | AH-60001-AR Ind STM Policy SIGNED FINAL |

1.26.10.pdf

No Rate/Rule Schedule items changed.

## Response 2

Comments: The arbitration paragraph has been removed.

**Related Objection 1**

Applies To:

- POLICY, AH-60001-AR (Form)

Comment:

As a reminder, Arkansas does not allow Binding Arbitration. Please refer to ACA 23-79-203.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|---|---|---|---|---|---|---|
| *POLICY* | *AH-60001-AR* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | *43.100* | AH-60001-AR Ind STM Policy 2-10.pdf |
| ***Previous Version*** | | | | | | | |
| *POLICY* | *AH-60001-AR* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | *43.100* | AH-60001-AR Ind STM Policy SIGNED FINAL 1.26.10.pd |

f

No Rate/Rule Schedule items changed.

## Response 3

Comments: The time frame has been changed from 6 months to 12 months.

**Related Objection 1**

Applies To:

- POLICY, AH-60001-AR (Form)

Comment:

Under Premium Changes, there is a statement that says that the premium rates will not be changed more often than once every (6) months after the first policy anniversary.

It has been our Departmental policy for years that after the first annual anniversary of a policy, premiums will not be changed more than once in a twelve (12) month period.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|---|---|---|---|---|---|---|
| *POLICY* | *AH-60001-AR* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | *43.100* | AH-60001-AR Ind STM Policy 2-10.pdf |
| ***Previous Version*** | | | | | | | |
| *POLICY* | *AH-60001-AR* | | *Policy/Contract/Fraternal Certificate* | *Initial* | | *43.100* | AH-60001-AR Ind STM Policy |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

SIGNED FINAL 1.26.10.pdf

No Rate/Rule Schedule items changed.

I trust that these revisions will allow the Department to complete its review of this filing. However, please contact me if you have any additional comments.

Sincerely,
Renee Weaver

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

# Form Schedule

**Lead Form Number: AH-60001-AR**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 02/03/2010 | AH-60001-AR | Policy/Contract/Fraternal Certificate | POLICY | Initial | | 43.100 | AH-60001-AR Ind STM Policy 2-10.pdf |
| Approved-Closed 02/03/2010 | AH-60008 | Application/Enrollment Form | APPLICATION | Initial | | 43.100 | AH-60008 STM Enroll.pdf |
| Approved-Closed 02/03/2010 | AH-60008IR | Application/Enrollment Form | RE-APPLICATION | Initial | | 43.100 | AH-60008IR STM Individual Re-Application.pdf |
| Approved-Closed 02/03/2010 | AH-60009IP | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | BENEFIT CHANGE ENDORSEMENT | Initial | | 43.100 | AH-60009IP-STM Policy Benefit Change Amendment.pdf |
| Approved-Closed 02/03/2010 | AH-60014I | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | WAIVER OF PRE-X ENDORSEMENT | Initial | | 43.100 | AH-60014I STM WAIVER OF PRE-EXISTING Rider.pdf |

# Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [399 Park Avenue, 8th Floor, New York, NY 10022]

## SHORT TERM MEDICAL INSURANCE APPLICATION

**[Applicant:** Name _____ Date of Birth _____ Age____Sex___Ht. _____ Wt. _____

Social Security Number _____ Occupation _____ Telephone _____

Street Address _____ City _____ State _____ Zip Code _____

Billing Address (If Different) _____ City _____ State _____ Zip Code _____

E-Mail Address _____

**COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:**

**Spouse:** Name: _____Date of Birth _____ Age___ Sex ____ Ht. _____ Wt. _____

Occupation _____

Child's Name _____ Date of Birth _____ Age _____

Child's Name _____ Date of Birth _____ Age _____

Child's Name _____ Date of Birth _____ Age _____]

---

**[Complete the Following Choices:**

**1-☐ Coverage Effective Date:**
☐ Day After US Post Office Date Stamp ☐ Later Effective Date: _____

**2-☐ Coverage Length:**

Prepaid: ☐ 30 days, ☐ 60 days ☐ 90 days, ☐ 120 days ☐ 150 days, ☐ 180 days
List the number of days if not listed above (must be more than 30 days):_____

| **1-6 Months Coverage:** | ☐ **Up to 6 Months Coverage:** | ☐ **Up to 12 Months Coverage:** |
|---|---|---|
| ☐ Single Prepay<br>☐ Monthly Payments | Monthly Payments Available Only | Monthly Payments Available Only |

**3.-☐ Coinsurance Choice:**
[☐ 80/20 of $5,000] [☐ 50/50 of $5,000] [☐ 80/20 of $10,000] [☐ 50/50 of $10,000]

**4-☐ Deductible:**
**[**☐ $250] [ ☐ $500] [ ☐ $1,000] [ ☐ $2,500] [☐ $5,000] [☐ $7,500] [☐ $10,000]

**5-☐ Payment Method:**
☐ Check or Money Order ☐ Credit Card ☐ Monthly Automatic Bank Withdrawal ]

---

**[Answer the Following Medical History Questions:**

***Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage and that of my dependents. In the event of rescission or termination for any reason, the Insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.***

1. Will there be any other health insurance in force on the policy date? ☐ **Yes** ☐ **No**
2. Is the proposed insured, spouse, or any dependent child now pregnant, undergoing infertility treatment, or in the process of adoption? ☐ **Yes** ☐ **No**
3. Is the proposed insured currently eligible for Medicaid? ☐ **Yes** ☐ **No**
4. Has any person proposed for coverage been declined for health insurance in the past 12 months for a condition that is still present)? ☐ **Yes** ☐ **No**
5. Within the past 5 years, have you or any person to be insured been aware of, diagnosed, treated by a member of the medical profession, or taken medication for cancer or a tumor, stroke, heart disease including heart attack, had heart surgery, COPD (Chronic Obstructive Pulmonary Disease) or emphysema, kidney disorder or disease, liver disorder or disease, neurological disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, degenerative joint disease of the knee or hip, diabetes (not applicable to DC residents), alcohol abuse or chemical dependency, or does anyone listed on the application currently weigh over 250 pounds (women) or over 300 pounds (men)? ☐ **Yes** ☐ **No**
6. Have you or any person to be insured been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder such as HIV? (Residents of WI do not need to disclose HIV test results.) ☐ **Yes** ☐ **No**
7. Has any other person proposed for coverage not been a legal resident of the United State for the last 12 consecutive months? ☐ **Yes** ☐ **No**

**NOTE: IF "YES" IS ANSWERED ON ANY QUESTION FROM 1 THROUGH 7, COVERAGE CANNOT BE ISSUED]**

1. [I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.

2. I hereby request coverage under the policy issued by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the policy. I understand that health insurance benefits are excluded for pre-existing conditions.

3. I hereby authorize any hospital, clinic, physician, surgeon, practitioner or insurance company to furnish the Insurer or its representative with any and all information concerning any sickness or injury I or my dependents may have suffered, including copies of all hospital or medical records. A copy of this authorization shall be considered as valid as the original and remains in effect for 2 years from the date of my signature. I understand that I may revoke this authorization at any time by sending a written revocation to the Company. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right the Company has to contest an insurance policy or to contest a claim under an insurance policy. I understand that if I revoke this authorization, the Company may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

4. I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Starr Indemnity & Liability Company. I further acknowledge that the person who solicited this application and upon whose explanation or benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.

5. I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage.

**I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had in the past.**

**Signature of Applicant:** _____ **Date:** _____

**Signature of Spouse:** _____ **Date:** _____

I certify that I have read the applicable Fraud Notice.

**[Fraud Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud].**

I have truly and accurately recorded the information supplied by the Applicant._____
Agent Signature

## STATE-SPECIFIC REQUIRED FRAUD WARNINGS

**Arkansas and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California Residents:** Any person who knowingly presents a false or fraudulent claim of payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and confinement in state prison.

**District of Columbia Residents:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Missouri Residents:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not answer it.

**New Mexico Residents**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which may be a crime and subjects such person to criminal and civil penalties.

**Washington Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

# Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [90 Park Avenue, 7th Floor, New York, NY 10016]

## SHORT TERM MEDICAL INSURANCE APPLICATION

**[Applicant:** Name _____ Date of Birth _____ Age____Sex___Ht. _____ Wt. _____

Social Security Number _____ Occupation _____ Telephone _____

Street Address _____ City _____ State _____ Zip Code _____

Billing Address (If Different) _____ City _____ State _____ Zip Code _____

E-Mail Address _____

**COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:**

**Spouse:** Name: _____Date of Birth _____ Age___ Sex ____ Ht. _____ Wt. _____

Occupation _____

Child's Name _____ Date of Birth _____ Age _____

Child's Name _____ Date of Birth _____ Age _____

Child's Name _____ Date of Birth _____ Age _____]

---

**[Complete the Following Choices:**

**1-☐ Coverage Effective Date:**
☐ Day After US Post Office Date Stamp ☐ Later Effective Date: _____

**2-☐ Coverage Length:**

| Prepaid: ☐ 30 days, ☐ 60 days ☐ 90 days, ☐ 120 days ☐ 150 days, ☐ 180 days<br>List the number of days if not listed above (must be more than 30 days):_____ | | |
|---|---|---|
| **1-6 Months Coverage:**<br>☐ Single Prepay<br>☐ Monthly Payments | ☐ **Up to 6 Months Coverage:**<br>Monthly Payments Available Only | ☐ **Up to 12 Months Coverage:**<br>Monthly Payments Available Only |

**3.-☐ Coinsurance Choice:**
[☐ 80/20 of $5,000] [☐ 50/50 of $5,000] [☐ 80/20 of $10,000] [☐ 50/50 of $10,000]

**4-☐ Deductible:**
**[**☐ $250] [ ☐ $500] [ ☐ $1,000] [ ☐ $2,500] [☐ $5,000] [☐ $7,500] [☐ $10,000]

**5-☐ Payment Method:**
☐ Check or Money Order ☐ Credit Card ☐ Monthly Automatic Bank Withdrawal

---

1. I hereby request coverage under the policy issued by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the policy.

2. I understand that my coverage will not become effective unless the company has received this enrollment form within [30 days] prior to the end of my current coverage period and I have paid the required premium.

3. I hereby authorize any hospital, clinic, physician, surgeon, practitioner or insurance company to furnish the Insurer or its representative with any and all information concerning any sickness or injury I or my dependents may have suffered, including copies of all hospital or medical records. A copy of this authorization shall be considered as valid as the original and remains in effect for 2 years from the date of my signature. I understand that I may revoke this authorization at any time by sending a written revocation to the Company. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right the Company has to contest an insurance policy, or to contest a claim under an insurance policy. I understand that if I revoke this authorization, the Company may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

4. I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Starr Indemnity & Liability Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.

5. I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage.

**Pre-existing Conditions**.
I understand that any condition(s) that were diagnosed and covered under my current short term medical coverage period will not be subject to the pre-existing conditions limitation under this coverage period, provided this enrollment form is received by the Company on time. I understand that any condition(s) that were excluded because of a pre-existing condition under my current short term medical coverage period will continue to be subject to the pre-existing conditions limitation under my new coverage period. I understand that if the Company does not receive this enrollment form on time, I will be required to re-apply for coverage subject to underwriting and the pre-existing condition limitation will apply to all conditions**.**

**Signature of Applicant:** _____ **Date:** _____

**Signature of Spouse:** _____ **Date:** _____

I certify that I have read the applicable Fraud Warning.

**[Fraud Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud].**

I have truly and accurately recorded the information supplied by the Applicant._____
Agent Signature

## STATE-SPECIFIC REQUIRED FRAUD WARNINGS

**Arkansas and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California Residents:** Any person who knowingly presents a false or fraudulent claim of payment of a loss is guilty of a crime and may be subject to civil fines and confinement in state prison.

**District of Columbia Residents:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**New Mexico Residents**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which may be a crime and subjects such person to criminal and civil penalties.

**Washington Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

# Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [90 Park Avenue, 7th Floor, New York, NY 10016]

## Amendment

**Policy Number:** [123456] **Effective Date:** [07-01-09 at 12:01 A.M.]

**Policyholder:** [XXXX] **Amendment No.: [x]**

This Amendment form is made a part of the Policy to which it is attached as of the Effective Date shown above. If no Effective Date is shown, this Amendment takes effect as of the Policy Effective Date and will expire concurrently with the Policy unless otherwise terminated. This Amendment is subject to all of the terms, limitations and conditions of the Policy except as they are changed herein.

***[SAMPLE TEXT***

A. The following is added to the Schedule:

| | |
|---|---|
| **ORGAN, TISSUE TRANSPLANTS:** | |
| Maximum Lifetime Benefit for all Covered Expenses: | $50,000 per person. |

B. The following benefit is hereby added to and made a part of the section entitled COVERED EXPENSES:

**Organ or Tissue Transplants:** The Coinsurance Percentage for an organ or tissue transplant, up to the Lifetime Maximum Amount shown in the Schedule for this benefit. This benefit shall include all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, including the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

Covered Expenses do not include organ or tissue transplants which:

a. Are animal-to-human transplants;
b. Use artificial or mechanical organs;
c. Are Experimental or Investigative; or
d. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness.

**]**

Signed for STARR INDEMNITY & LIABILITY COMPANY:

[Charles H. Dangelo], President [Honora M. Keane], General Counsel

**Starr Indemnity & Liability Company**

Dallas, Texas

Administrative Office: [90 Park Avenue, 7th Floor, New York, New York 10016]

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## WAIVER OF PRE-EXISTING CONDITIONS RIDER

The Policy to which this Rider is attached is amended as follows.

The following paragraphs are hereby added to the **PRE-EXISTING CONDITIONS LIMITATION** provision:

A medical condition or Sickness shall not be considered a Pre-Existing Condition if the following conditions are met:

1. The medical condition or Sickness began or symptoms started while the Covered Person was insured with Us under previous Short Term Medical Insurance; and
2. The Effective Date of the Short Term Medical Policy to which this Rider is attached is no later than the day after the termination date of the prior Short Term Medical Policy, referenced in 1. above, that had been issued by Us to the Covered Person.

If the Covered Person was insured under a Short Term Medical plan with Us which terminated on the day before the Effective Date of the prior Short Term Medical plan described in 2. above, the waiver of Pre-existing Conditions will also be valid for any medical condition or Sickness which began or for which symptoms started under that coverage as well.

We will only allow a Covered Person to apply for and be issued coverage in which the Pre-existing Conditions are waived, two additional times after the initial Policy is issued.

Nothing contained in this Rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of this or any Policy other than as stated above.

The Effective Date of this Rider is the Effective Date of the Policy to which it is attached.

Signed for Starr Indemnity & Liability Company by:

[Charles H. Dangelo], President  [Honora M. Keane], General Counsel

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

# Supporting Document Schedules

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 02/03/2010 |

**Comments:**
Consumer info is included on the face page of the Policy.
**Attachments:**
SIGNED CERTIFICATION 1 27 10.pdf
STM Readability IND SIGNED 05 20 09.pdf

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Application | Approved-Closed | 02/03/2010 |

**Comments:**
Application is new and under the forms tab

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Health - Actuarial Justification | Approved-Closed | 02/03/2010 |

**Comments:**
**Attachments:**
AR CV Starr STM Act Mem - AR.pdf
AR CV Starr STM Rate Sheet - AR - 12 Mon.pdf

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Outline of Coverage | Approved-Closed | 02/03/2010 |

**Comments:**
**Attachment:**
AH-60001-AR-OOC.pdf

| | **Item Status:** | **Status Date:** |
|---|---|---|

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

**Satisfied - Item:** Authorization Letter — Approved-Closed — 02/03/2010

**Comments:**

**Attachment:**

Innovative Compliance Solutions Auth Letter 11.13.09.pdf

| | **Item Status:** | **Status Date:** |
|---|---|---|
| **Satisfied - Item:** Explanation of Variables | Approved-Closed | 02/03/2010 |

**Comments:**

**Attachment:**

EOV - STM Starr IND.pdf

**ARKANSAS**
**CERTIFICATE OF COMPLIANCE**

Starr Indemnity & Liability Company hereby certifies that the policy forms listed below are in compliance with all of the requirements of Arkansas Insurance Department Rule and Regulation 19. The benefits/coverage provided by the forms listed below are available to, and will be administered, in a non-discriminatory manner.

Honora Keane

(Signature)

Honora Keane M. Keane, General Counsel

(Title)

January 27, 2010

(Date)

**Policy Form Numbers:**
AH-60001-AR, AH-60001-AR-OOC, AH-60008, AH-60008IR, AH-60009IP, AH-60014I

# CERTIFICATION OF COMPLIANCE
# FOR READABILITY

| Form Number(s) | Flesch Readability Score |
|---|---|
| AH-60001 et al | 43.1 |

I hereby certify on behalf of Starr Indemnity and Liability Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores.

Honora Keane

Honora M. Keane

General Counsel

Title

Dated: December 1, 2009

# Actuarial Memorandum
# Starr Indemnity & Liability Company
# Dallas, Texas
# AH-60001-AR

1. Scope and Purpose

This is an initial filing for the short term major medical insurance policy of Starr Indemnity & Liability Company. This actuarial memorandum has been prepared to accompany the filing of the above policy with state insurance departments. This actuarial memorandum is not intended for any other purpose.

2. Benefit Description

The benefits provided by this policy are medical expense. Benefit schedules are included with the original forms filed herein.

3. Applicability

The rates apply to new issues.

4. Renewability

Non-renewable term coverage.

5. Renewal Rates

The policy is for short-term coverage, therefore there are no renewal rates.

6. Morbidity

Rates were established using available industry information on similar short-term medical products.

7. Persistency

In our experience, lapse rates for this type of product run from 16% - 20% per month for monthly payment up to 6 months and 6% - 10% per month for monthly payment up to 12 months.

8. Expenses

| | |
|---|---|
| Commissions | 32.00% |
| Administration | 8.00% |
| Carrier Fee (including taxes) | 4.00% |
| Total | 44.00% |

9. Target Underwriting Gain

This policy is priced with an 8% profit margin on gross premium.

10. Marketing Method

Business is distributed through independent agents and general agents.

11. Underwriting

Business is subject to individual underwriting via a short application with yes/no answers to health-related questions.

12. Termination

The policy may be terminated by either the Policyholder or the Company upon 30 days written notice.

13. Premium Classes

Premium classes used are age, gender, geography, family structure, duration of coverage, payment mode, and plan design, in accordance with state limitations.

14. Issue Age Range

Allowable issue ages are 2 through age 64. The maximum term of coverage is to attainment of age 65.

15. Area Factors

Area factors are categorized by 3-digit zip codes, and the relative factors used are based on available industry information.

16. Premium Modalization Rules

All premiums are earned on a monthly basis. A discount is provided for prepayment for a term of coverage up to 6 months.

17. Trend Assumptions

A trend factor of approximately 1% per month is used to project future expected claims and is included in the premium rate structure.

18. Future Anticipated Loss Ratio

The anticipated loss ratio for this policy is expected to be 48.0%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

19. Expected Average Annual Premium

The average annual premium is heavily dependent on geographic area, age, gender, family structure, duration of coverage, and plan design. We expect an average annual premium of approximately $600.

20. History of Rate Adjustments

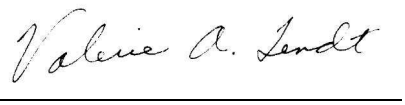
This is an initial rate filing.

21. Proposed Effective Date

The proposed effective date is upon approval.

22. Actuarial Certification

I hereby certify that to the best of my knowledge and judgment, the enclosed filing is in compliance with the applicable laws of this state and the proposed premium rates, which are reasonable in relation to the benefits provided, are not excessive, inadequate, or unfairly discriminatory.



Valerie A. Lendt, FSA, MAAA
President
Pricing & Analysis Resources, Inc.
June 3, 2009

# Starr Indemnity & Liability Company

Dallas, Texas

## Short-Term Medical Rate Sheet

### Base Rates

| Age | Sex | Monthly Up to 6 Months | Monthly Up to 12 Months | Prepay Per Day |
|---|---|---|---|---|
| 2-19 | Male | 35.84 | 51.25 | 0.88 |
| 20-24 | Male | 41.91 | 59.92 | 1.04 |
| 25-29 | Male | 37.35 | 53.41 | 0.92 |
| 30-34 | Male | 43.10 | 61.64 | 1.06 |
| 35-39 | Male | 59.60 | 85.23 | 1.47 |
| 40-44 | Male | 80.49 | 115.10 | 1.98 |
| 45-49 | Male | 107.18 | 153.27 | 2.65 |
| 50-54 | Male | 144.48 | 206.61 | 3.57 |
| 55-59 | Male | 201.62 | 288.32 | 4.98 |
| 60-64 | Male | 273.49 | 391.09 | 6.75 |
| 2-19 | Female | 45.39 | 64.91 | 1.12 |
| 20-24 | Female | 52.62 | 75.24 | 1.30 |
| 25-29 | Female | 47.46 | 67.87 | 1.18 |
| 30-34 | Female | 52.80 | 75.51 | 1.30 |
| 35-39 | Female | 64.65 | 92.45 | 1.60 |
| 40-44 | Female | 83.97 | 120.08 | 2.08 |
| 45-49 | Female | 104.92 | 150.03 | 2.59 |
| 50-54 | Female | 140.57 | 201.02 | 3.48 |
| 55-59 | Female | 180.68 | 258.37 | 4.46 |
| 60-64 | Female | 228.67 | 327.00 | 5.65 |
| Per | Child | 37.98 | 54.31 | 0.93 |

### Area Factors

| Area | Factor |
|---|---|
| A | 0.705 |
| B | 0.750 |
| C | 0.795 |
| D | 0.841 |
| E | 0.886 |
| F | 0.943 |
| G | 1.000 |
| H | 1.057 |
| I | 1.125 |
| J | 1.193 |
| K | 1.261 |
| L | 1.341 |
| M | 1.420 |
| N | 1.500 |
| O | 1.591 |
| P | 1.693 |
| Q | 1.795 |
| R | 1.898 |
| S | 1.970 |

### Deductible Factors

| Deductible | Monthly Pay Up to 6 Months | Monthly Pay Up to 12 Months | Prepay |
|---|---|---|---|
| $ 250 | 2.10 | 2.10 | 2.10 |
| $ 500 | 1.45 | 1.45 | 1.45 |
| $ 1,000 | 0.95 | 0.95 | 0.95 |
| $ 2,500 | 0.58 | 0.58 | 0.58 |
| $ 5,000 | 0.48 | 0.48 | 0.48 |
| $ 7,500 | 0.38 | 0.38 | 0.39 |
| $ 10,000 | 0.31 | 0.31 | 0.32 |

### Coinsurance Factors

| Deductible | 80/20 | 50/50 |
|---|---|---|
| $ 250 | 1.00 | 0.83 |
| $ 500 | 1.00 | 0.84 |
| $ 1,000 | 1.00 | 0.85 |
| $ 2,500 | 1.00 | 0.86 |
| $ 5,000 | 1.00 | 0.87 |
| $ 7,500 | 1.00 | 0.88 |
| $ 10,000 | 1.00 | 0.89 |

### Plan Factors

| Plan | Deductible | Monthly Pay Up to 6 Months | Monthly Pay Up to 12 Months 80/20 | Monthly Pay Up to 12 Months 50/50 | Prepay |
|---|---|---|---|---|---|
| Regular | All | 1.000 | 1.000 | 1.000 | 1.000 |
| Lite | All | 0.640 | 0.600 | 0.600 | 0.625 |
| 12x3 | $ 500 | | 0.816 | 0.834 | |
| | $ 1,000 | | 0.846 | 0.864 | |
| | $ 2,500 | | 0.870 | 0.894 | |
| | $ 5,000 | | 0.882 | 0.906 | |
| | $ 7,500 | | 0.894 | 0.918 | |
| | $ 10,000 | | 0.906 | 0.930 | |

### Stop-Loss Factors

| Stop-Loss | Factor |
|---|---|
| $ 5,000 | 1.00 |
| $ 10,000 | 0.94 |

* Formula for arriving at the final rate:

Final Rate = Round(Base Rate * Area Factor * Deductible Factor * Coinsurance Factor * Plan Factor * Stop-Loss Factor,2)

# Starr Indemnity & Liability Company

Dallas, Texas

Rating Areas

| Zip Code | Area |
|---|---|
| Alaska | |
| 995, 997 | H |
| 996, 998-999 | G |
| | |
| Alabama | |
| 350-352, 362 | M |
| 354-361, 363-369 | K |
| | |
| Arkansas | |
| 716-718 | G |
| 719-720, 722-723, 725-726, 728 | F |
| 721, 724, 727, 729 | E |
| | |
| Arizona | |
| 850-865 | A |
| | |
| California | |
| 900-908 | S |
| 909-919, 926-928, 940-948 | R |
| 920, 922-925, 930, 932-935, 939, 952, | |
| 954-957, 959-960, 962-966 | O |
| 921, 931, 949-951, 953, 958 | Q |
| 936-938, 961 | N |
| | |
| Colorado | |
| 800-816 | I |
| | |
| Delaware | |
| 197-199 | J |
| | |
| District of Columbia | |
| 200-205 | K |
| | |
| Florida | |
| 331-332 | P |
| 330, 333-334, 340 | O |
| 320-322, 324-326, 328-329, 335-337, | |
| 341-342, 349 | L |
| 323, 327, 338-339, 343-344, 346-348 | K |

| Zip Code | Area |
|---|---|
| Kansas | |
| 661-662, 672 | D |
| 660, 663-671, 673-679 | C |
| | |
| Kentucky | |
| 419 | K |
| 412-413 | J |
| 406, 409, 411, 414-418 | I |
| 400-405, 407-408, 421-422, 425-427 | H |
| 410, 423-424 | G |
| 420 | E |
| | |
| Louisiana | |
| 701 | M |
| 700, 702-714 | L |
| | |
| Maryland | |
| 210-212 | F |
| 206-209, 214, 217, 219 | E |
| | |
| 213, 215-216, 218 | D |
| | |
| Maine | |
| 039-049 | I |
| | |
| Michigan | |
| 480, 482 | E |
| 481, 483, 487, 491, 493-494 | D |
| 484-485, 489, 492, 497-499 | C |
| 486, 488, 490, 495-496 | B |
| | |
| Minnesota | |
| 551, 554, 559 | H |
| 550, 552-553, 555-558, 560-567 | F |
| | |
| Missouri | |
| | |
| 641, 649-651 | C |
| 630-640, 642-648, 652-658 | B |

| Zip Code | Area |
|---|---|
| New Mexico | |
| 870, 872-874, 876-881, 882-884 | H |
| 871, 875 | G |
| | |
| Ohio | |
| 441 | D |
| 431-434, 438-440, 443-452 | C |
| 430, 435-437, 442, 453-459 | B |
| | |
| Oklahoma | |
| 730-749 | F |
| | |
| Oregon | |
| 971-972 | G |
| 970, 973-979 | F |
| | |
| Pennsylvania | |
| 190-192 | L |
| 151-152, 176, 189, 193-194 | K |
| 150, 153-157, 159-168, 171-173, 175, | |
| 177-188, 195-196 | J |
| 158, 169-170, 174 | I |
| | |
| Rhode Island | |
| 028-029 | J |
| | |
| South Carolina | |
| 290-299 | G |
| | |
| South Dakota | |
| 571 | H |
| 570, 572-577 | G |
| | |
| Tennessee | |
| 372, 374-375, 379, 381 | I |
| 370-371, 373, 376-378, 380, 382-385 | H |

# Starr Indemnity & Liability Company

Dallas, Texas

Rating Areas

| | |
|---|---|
| **Georgia** | |
| 311 | J |
| 300-303, 307-309, 312-314, 318-319, 398-399 | H |
| 304-306, 310, 315 | G |
| 316-317 | F |
| **Hawaii** | |
| 967-968 | H |
| **Idaho** | |
| 832-838 | I |
| **Illinois** | |
| 600-606 | K |
| 607-608 | I |
| 611, 618-619, 627 | H |
| 609-610, 612-617, 620-626, 628-629 | G |
| **Iowa** | |
| 502-506, 509, 511, 513, 520-523, 527-528 | G |
| 500-501, 507-508, 510, 512, 514-516, 524-526 | F |
| **Indiana** | |
| 464 | G |
| 460-463, 465-466, 468, 470, 472, 475-478 | D |
| 467, 469, 471, 473-474, 479 | C |
| **Mississippi** | |
| 386-397 | L |
| **Montana** | |
| 590-599 | K |
| **North Carolina** | |
| 273-277, 281-282 | G |
| 270-272, 278-280, 283-289 | F |
| **North Dakota** | |
| 580-588 | F |
| **Nebraska** | |
| 681, 685 | G |
| 680, 683-684, 686-689, 690-693 | F |
| **Nevada** | |
| 889-898 | L |
| **New Hampshire** | |
| 030-038 | G |
| **Texas** | |
| 770-777 | M |
| 750-753 | L |
| 754-769, 778-799 | K |
| **Utah** | |
| 840-847 | D |
| **Virginia** | |
| 201, 220, 222-223, 225, 227-228, 230-231 | I |
| 221, 224, 226, 229, 232-234, 235-246 | G |
| **Washington** | |
| 980-994 | H |
| **Wisconsin** | |
| 531-532, 536-537 | I |
| 530, 534-535, 538-549 | G |
| 533 | F |
| **West Virginia** | |
| 250-253, 255-257 | K |
| 247-249, 254, 258-268 | J |
| **Wyoming** | |
| 820-831 | J |

# Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [399 Park Avenue, 8th Floor, New York, NY 10022]

## AH-60001-AR-OOC INDIVIDUAL SHORT TERM MEDICAL EXPENSE COVERAGE

## OUTLINE OF COVERAGE

Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Individual short term medical expense coverage is designed to provide limited duration for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

This Policy limits Covered Expenses to Usual, Reasonable and Customary charges which may be less than the billed charges. This means that if a provider charges more than the Usual, Reasonable and Customary charge, you may be responsible for the difference. This plan pays an overall lifetime maximum of [$500,000-$2,000,000] for each insured. However certain benefits have individual limitations as shown below and in the Policy, which are included in the overall lifetime maximum.

The following is a brief description of the Usual, Reasonable and Customary charges for Covered Expenses covered under the Policy. You are responsible for your deductible and any coinsurance percentages up to an out of pocket maximum of [$5,000-$20,000]. See your Policy for a complete list of all benefits.

- [Hospital Charges —medical care and treatment.
- Ambulatory Surgical Center charges.
- Intensive Care — up to three times the average semi-private room rate.
- Physicians Services for diagnosis, treatment and surgery.
- Anesthesia, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of necessary medical supplies.
- Blood or blood derivatives and their administration.
- X-ray exams, laboratory tests and analyses.
- X-ray and radioactive isotope therapy.
- Ambulance Services — $250 per trip
- Acquired Immune Deficiency Syndrome (AIDS).
- Home Health Care
- Hospice
- Mammography/Pap Smear screens and exams
- Breast Reconstructive Surgery]

**Usual, Reasonable and Customary** means:

1. With respect to fees or charges, fees for medical services or supplies which are:
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received, whichever is less; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

### PRE-ADMISSION CERTIFICATION NOTICE

This plan requires a Pre-Admission Certification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed

Hospitalization;
2. Within 48-hours from the time the person is in stable condition following an emergency admission, or as soon as reasonably possible if the person's medical condition prevents or delays such notification; or
3. Within 48-hours of delivery (96 hours for cesarean section) for complicated childbirth or as soon as reasonably possible.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%,** unless the Covered Person is incapacitated and unable to contact Us in such cases, the Covered Person must contact Us as soon as possible.

**Exclusions and Limitations.**

We will not pay for loss or expense caused by or resulting from any of the following:

1. [Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision;]
2. [Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated. except in accordance with the Extension of Benefits provision;]
3. [Expenses to treat complications resulting from treatment of conditions which are not covered under the Policy. This does not include Emergency Services as defined;]
4. [Experimental or Investigative services or treatment. "Experimental or Investigative" means services, supplies, devices, treatments, procedures, or drugs that have no been recognized as generally accepted medical treatments. Our determination of what constitutes Experimental or Investigative treatment will be based on, but not limited to, the approval of treatments from the American Medical Association, the U.S. Food and Drug Administration, and the Administrative Procedure Act. Experimental or Investigative includes treatments that have not been demonstrated through sufficient peer-reviewed medical literature to be safe and effective for the proposed use;]
5. [Expenses for purposes determined by Us to be educational, except when specifically covered;]
6. [Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies;]
7. [Expenses You [or Your Covered Dependent] are not required to pay, or which would not have been billed, if no insurance existed;]
8. [Expenses to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan;]
9. [Charges that are eligible for payment by Medicare or any other government program except Medicaid;]
10. [Costs for care in government institutions unless You [or Your Covered Dependent] are obligated to pay for such care;]
11. [Expenses for the treatment of an occupational Injury or Sickness which are paid under any Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under any Workers' Compensation ;]
12. [Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited);]
13. [Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to You on a pro rated basis;]
14. [Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;]
15. [Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault;]
16. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy;
17. [Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital except as specifically covered under the Policy, This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth;]
18. [Charges for voluntary termination of normal pregnancy, normal childbirth or elective cesarean section;]
19. [The cost of any drug, including birth control pills, supply, treatment or procedure that prevents conception or childbirth;]
20. [Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate;]

21. [Expenses for sterilization or reversal of sterilization;]
22. [Services, supplies or treatment related to sex transformation or sex dysfunction or inadequacies;]
23. [Costs for physical exams or other services not needed for medical treatment, except as specifically covered;]
24. [Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered;]
25. [Expenses for the treatment of Mental Illness or Nervous Disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind, unless specifically covered;]
26. [The costs of treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction, unless specifically covered;]
27. [Expenses incurred in the treatment of Injury or Sickness sustained by voluntary use of alcohol, illegal drugs or hallucinogenics;]
28. [The cost of programs, treatment, or procedures for tobacco use cessation;]
29. [Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, whether while sane or insane;]
30. [The cost of dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered;]
31. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, except as specifically covered;
32. [Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to asses the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts;]
33. [The costs for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids except as specifically covered;]
34. [The costs of cosmetic or reconstructive procedures, services or supplies, except as specifically covered;]
35. [Charges for breast reduction or augmentation or complications arising from these procedures;]
36. Outpatient Prescription or Legend Drugs, medications, vitamins and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor;
37. [The cost of any drug or other item used to treat hair loss;]
38. [Expenses incurred in the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person;]
39. [Expenses incurred in the treatment of acne or varicose veins;]
40. [The costs of weight loss programs, diets, or treatment of obesity;]
41. [Transportation charges, except as specifically covered;]
42. [Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital, unless specifically covered;]
43. [Costs of services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops, except as specifically covered;]
44. [Costs of services or supplies furnished or provided by a member of Your Immediate Family;]
45. [Expenses for diagnosis or treatment of a sleeping disorder;]
46. [Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests;]

47. [Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator);]
48. [The costs of services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits;]
49. [Expenses for surgery during the first 6 months after the Effective Date of Coverage for a Covered Person for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis or carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-Existing Conditions exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, herniorraphy, or cholecystectomies;]
50. [Knee Injury or Disorder: Expenses do not include charges incurred to diagnose or treat an Injury or disorder of the knee including surgery in excess of the Knee Injury or Disorder Maximum shown in the schedule;]
51. [Gallbladder Surgery: Expenses do not include charges incurred in excess of the Gallbladder Surgery Maximum shown in the Schedule;]
52. [Participating in [Interscholastic] [Intercollegiate] [Organized Competitive] Sports;
53. [Medical care, treatment, services, or supplies received outside of the United States or its possessions;]

**PRE-EXISTING CONDITIONS LIMITATION**

We will not provide benefits for any loss caused by or resulting from, a Pre-Existing Condition.

**"Pre-Existing Conditions"** mean any medical condition or Sickness for which medical advice, care, diagnosis, treatment, consultation, or medication was recommended by or received from a Doctor within the [24 months - 5 years] immediately prior to a Covered Person's Effective Date of Coverage. [This does not apply to congenital birth defects or anomalies of newborn infants, foster children and adopted children when you have paid the additional premium within 30 days of acquiring such dependent.]

**"Consultation"** means evaluation, diagnosis or medical advice was given with or without the necessity of a personal examination or visit.

### Renewability

THIS IS NON-RENEWABLE SHORT-TERM INSURANCE AND MAY NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD.

### Premium

The first premium is due on the Effective Date. Subsequent premiums are due [monthly], in advance, on the anniversary date and month of the Effective Date. Except as otherwise provided herein, all such insurance will terminate on the premium due date, except as provided in the Grace Period provision, if premiums are not paid when due.

The Company will determine the premium for each Covered Person. We have the right to change premium rates on any premium due date by giving you [45-days] advance written notice of such change. The premium rates may also be changed at any time the terms of the Policy are changed.

# Starr Indemnity & Liability Company

399 Park Avenue, 8th Floor,
New York, NY 10022

November 13, 2009

NAIC Company Code: 38318

Re: See Attached Forms Listing

Please accept this letter as authorization from Starr Indemnity & Liability Company (the "Company") for Renee Weaver of Innovative Compliance Solutions of Anoka, Minnesota to file any or all policy forms and rate filings as referenced on the attached form listing on behalf of the Company.

Sincerely,

Honora M. Keane
General Counsel

**STARR INDEMNITY & LIABILITY COMPANY**
**INDIVIDUAL SHORT TERM MEDICAL INSURANCE**
**FORMS AH-60001 ET AL**
**EXPLANATION OF VARIABLES**

**All state mandated benefits within text that is bracketed would not be altered below that which is required by the state.**

# POLICY

**FACE PAGE**
Policyholder name, Policy Number, Coverage Period, Effective Date and Termination Date will be customized per the Company.
10 day Free Look – variable by omission
Signatures – current signatures will be shown.

**TABLE OF CONTEXTS**
Variable to include applicable provisions.

**SCHEDULE**
Section I
Deductible: Benefit range is shown. Family deductible text is variable by omission. When included the range is 1-4
Coinsurance: Range for percentage payable and limits are shown. Lifetime maximum: Benefit range is shown.

Section II
*Hospital Covered Expenses*
The percentage range is shown. Inside limits are variable by omission. When inside limits are included the range for hospital is $1,000-2,000 and for ICU is $1,250-$2,500.

*Other Covered Expenses*
- Ambulatory Surgical Center – the Outpatient Surgery is variable by omission. The percentage range is shown. Inside limits are variable by omission. When inside limits are included the maximum benefit range is $1,000-2,000.
- Outpatient Emergency Room – Variable by omission. The percentage range is shown. Inside limits are variable by omission. When inside limits are included the maximum benefit range is $500-1,000. The miscellaneous paragraph is variable by omission.
- Anesthetics Coinsurance - The percentage range is shown. Maximum percentage range is 20-25%.
- Assistant Surgeon - The percentage range is shown. Maximum percentage range is 20-25%
- Surgeons Assistant - The percentage range is shown. Maximum percentage range is 20-25%
- Inside Limits for Surgeons is variable by omission. When include the maximum amounts are variable as follows: $2,500-5,000 for surgery not to exceed $5,000-$10,000.
- In Hospital Doctor Visits - The percentage range is shown. Inside limits are variable by omission. When inside limits are included the maximum benefit range is $500-1,000
- Outpatient Misc. Charges - The percentage range is shown. Inside limits are variable by omission. When inside limits are included the maximum benefit range is $1,000-2,000.
- Doctors Office – Either the first paragraph or the second paragraph will be applicable. The copay for the first option range is $50-100, the maximum visits range is 3-6 visits. The copay for the second option range is $25-50, the maximum visits range is 4-8 visits with a maximum range of $1,000 – 2,000.
- Skilled Nursing – Per day amount range is $30-60. Number of days range is 30-60.
- Ambulance – dollar amount range is $250-500.
- Home Health Care – per day amount is $40-80. Number of visits range is 40-80 visits.
- Hospice Care – maximum amount range is $5,000-10,000.
- Knee Injury – variable by omission. When included, benefit amount range is $2,500-$5,000. Other conditions are variable by omission.
- Gallbladder surgery – variable by omission. When included, benefit amount range is $2,500-$5,000.
- Foreign Travel – Variable by omission. When included the deductible amount range is $250-500 and maximum benefit range is $25,000-50,000.

**DEFINITIONS**
Chemical Dependency is variable by omission
All reference to Dependents is variable by omission.
Mental Illness is variable by omission.
Participating Organization is variable by omission.

**ELIGIBILITY**
You – Bracketed items are variable by omission.
All reference to Dependents is variable by omission – when included:
Spouse – Bracketed items are variable by omission.
Dependent Children – 19 is the minimum age and 25 is the maximum age.

**EFFECTIVE DATES**
You and Eligible Dependents – The text within brackets is variable by content on a case-by-case basis. The Policyholder may add or remove other requirements. All reference to Dependents is variable by omission.

**TERMINATION OF INSURANCE**
All reference to Dependents is variable by omission.

**MEDICAL EXPENSE BENEFITS**
Covered Expenses - Text in brackets is variable by omission.

**EXCLUSIONS AND LIMITATIONS**
*Exclusions*
Items in brackets are variable by omission.

*Limitations*
Pre-x time frame range is 24 months to 5 years. Last paragraph is variable by omission.

**CLAIM PROVISIONS**
Notice of Claims – number of days is variable. Range is 20-30 days.
Claim Forms – Number of days is variable. Range is 90-180 days.
Proof of Loss – number of days is variable. Range is 90-180 days
Payment of Claims – amount is variable. Range is $250-$3000
Appeal on Claim Denial – number of days is variable. Range is 60-90 days

**GENERAL PROVISIONS**
Arbitration – Variable by omission.
Physical Exam and Autopsy- bracketed text is variable by omission.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *INCS-126474279* | *State:* | *Arkansas* |
| *Filing Company:* | *Starr Indemnity & Liability Company* | *State Tracking Number:* | *44720* |
| *Company Tracking Number:* | *AH-60001* | | |
| *TOI:* | *H16I Individual Health - Major Medical* | *Sub-TOI:* | *H16I.004 Short Term* |
| *Product Name:* | *CV Starr STM Ind* | | |
| *Project Name/Number:* | *CV Starr STM/Ah-60001* | | |

# Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---|---|---|---|---|
| 01/26/2010 | Form | POLICY | 02/02/2010 | AH-60001-AR Ind STM Policy SIGNED FINAL 1.26.10.pdf (Superceded) |

# Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [399 Park Avenue, 8th Floor, New York, New York 10022]
(hereafter referred to as "we," "us," and "our")

## SHORT TERM MEDICAL INSURANCE POLICY

| | |
|---|---|
| **[POLICYHOLDER:** | [John Doe] |
| **POLICY NUMBER:** | [12345] |
| **COVERAGE PERIOD:** | [6] Months |
| **EFFECTIVE DATE**: | [07-01-09] |
| **EXPIRATION DATE:** | [12-31-09] ] |

## SCOPE OF COVERAGE

**POLICY ISSUED TO THE POLICYHOLDER IN THE STATE OF ARKANSAS.**

This Policy is issued and delivered in the State shown above and shall be governed by its laws.

This Policy is the contract between the Policyholder and Starr Indemnity & Liability Company. This Policy contains the terms under which we agree to insure eligible persons and pay benefits, subject to the terms and conditions herein. References to Covered Dependents insurance apply only if You have elected such coverage. Coverage under this Policy is provided in consideration of payment of the initial premium and continued payment of premiums when due and that the answers in Your application are correct and complete.

**[10 DAY RIGHT TO RETURN THE POLICY**
If for any reason you are not satisfied with this Policy, you may return it to us within 10 days after you receive it. We will refund any premium paid and the Policy will be deemed void, just as though it had not been issued**]**.

**THIS POLICY IS NON-RENEWABLE TERM INSURANCE.**
**IT WILL NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD.**
**READ IT CAREFULLY.**

Signed for Starr Indemnity & Liability Company By:

[Honora M. Keane], General Counsel

[Charles H. Dangelo], President

**Policyholder Service Office of Company:** Starr Indemnity & Liability Company
**Address:** [399 Park Avenue, 8th Floor, New York, NY 10022]
**Telephone:** [1-800-XXX-XXXX]

If we at Starr Indemnity & Liability Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
[1200 West Third Street, Little Rock, Arkansas 72201-1904
Telephone: (501) 371-2640] or Toll-Free: [800-852-2640] ]

**TABLE OF CONTENTS**

The following provisions appear within this Policy in the following order:

## SCHEDULE

### PRE-ADMISSION CERTIFICATION NOTICE

This plan requires a Pre-Admission Certification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours from the time the person is in stable condition following an emergency admission, or as soon as reasonably possible if the person's medical condition prevents or delays such notification; or
3. Within 48-hours of delivery (96 hours for cesarean section) for complicated childbirth or as soon as reasonably possible.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%,** unless the Covered Person is incapacitated and unable to contact Us in such cases, the Covered Person must contact Us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.

## SECTION I

**The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount apply to each Covered Person and for ALL benefits, unless otherwise stated for a specific benefit in SECTION II.**

**THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON**

| | |
|---|---|
| **DEDUCTIBLE**: | [$250 - $10,000] |

[When [4] insured individuals in a family satisfy their Deductibles, the Deductibles for any remaining insured individual in the insured family are deemed satisfied for the remainder of the Coverage Period.]

| | |
|---|---|
| **COINSURANCE:** | |
| Coinsurance Percentage: | [50 - 100]% up to the Coinsurance Limit |
| Coinsurance Limit: | [$5,000-$20,000] |
| Thereafter | [80%-100%] |
| **LIFETIME MAXIMUM AMOUNT:** | [$500,000 - $2,000,000] |

## SECTION II

## MAXIMUM BENEFITS FOR EACH COVERED PERSON:

| | |
|---|---|
| **HOSPITAL COVERED EXPENSES:** | |
| **In Hospital Coinsurance Percentage** | [50 - 100%] [not to exceed [$1,000] per day including all miscellaneous medical charges**] |
| **In Hospital Intensive or Critical Care** | [50 - 100%] [not to exceed [$1,250] per day including all miscellaneous medical charges**] |
| **OTHER COVERED EXPENSES:** | |
| **Ambulatory Surgical Center [or Outpatient Hospital Surgery]:** | [50 - 100%] [not to exceed $1,000] per day including all miscellaneous medical expenses**] |
| **[Out-Patient Emergency Room:** This includes the emergency room physician charge, 24 hours surveillance and all miscellaneous medical charges**. | [50 - 100%] [not to exceed $500] per day**]** |

[**Miscellaneous medical charges include: X-rays, scans, laboratory, blood, therapy, oxygen, casts, splints, medicines, injections, chemotherapy and medical supplies.]

| | |
|---|---|
| **Anesthetics Coinsurance Percentage:** | [50 - 100%] up to [20%] of the surgeon's benefit |
| **Assistant Surgeon Coinsurance Percentage:** | [50 - 100%] up to [20%] of the surgeon's benefit |
| **Surgeon's Assistant Coinsurance Percentage:** | [50 - 100%] up to [20%] of the surgeon's benefit |

[The Surgeon, Anesthetics, Assistance Surgeon and Surgeon's Assistants benefits are limited to [$2,500] per surgery, for all Covered Expenses combined, not to exceed [$5,000] per Coverage Period.]

| | |
|---|---|
| **[In Hospital Doctor Visits**: | [50 - 100%] [not to exceed $500] per Hospital stay. **]** |
| **[Outpatient Miscellaneous Charges**: This does not include outpatient Hospital surgery | [50 - 100%] not to exceed [$1,000] per coverage period for all Covered Expenses combined. **]** |
| **Doctor's Office and Urgent Care Center:** | [For each visit after a [$50] copayment, not to exceed a maximum of [3] visits per Coverage Period. The first [3] visits are not subject to the Deductible. Visits in excess of the maximum of [3] visits per Coverage Period will be subject to the Deductible and Coinsurance.]<br><br>*OR*<br><br>[Up to [$25] per visit not to exceed [4] visits per Coverage Period. The balance of the office visit expense will be payable |

| | |
|---|---|
| | subject to the Deductible and Coinsurance, not to exceed [$1,000] per coverage period.] |
| **Skilled Nursing Facility:** | |
| Maximum Benefit Amount: | [$30] per day |
| Maximum Days: | [30] days per Coverage Period |
| **Ambulance Ground or Air:** | |
| Maximum Benefit: | [$250] per trip |
| **Home Health Care:** | |
| Maximum Benefit Amount: | [$40] per visit |
| Maximum Benefit Period: | [40] visits per Coverage Period |
| **Hospice Care:** | |
| Maximum Benefit: | [$5,000] per Coverage Period |
| **[Acquired Immune Deficiency Syndrome (AIDS)** | [$10,000] per Coverage Period |
| **[Knee Injury or Disorder:** | |
| Lifetime Maximum Benefit: | [$2,500] per Covered Person [for both left knee and right knee] [per left or right knee] ] |
| **[Gallbladder Surgery:** | |
| Lifetime Maximum Benefit: | [$2,500] per Covered Person ] |
| **[Organ, Tissue Transplants:** | |
| Lifetime Maximum Benefit for all Covered Expenses | [$50,000 - $150,000] per Covered Person] |
| **[Foreign Travel:** | |
| Foreign Travel Deductible: | [$250] per Covered Person |
| Lifetime Maximum Benefit: | [$25,000] per Covered Person] |
| **Temporomandibular Joint Disorder (TMJ):** | |
| Lifetime Maximum Benefit for authorized therapeutic procedures and Procedures for non-surgical treatment for TMJ: | [$3,500] per Covered Person |
| **Mammography** | |
| Maximum Benefit | [$50] for each screening mammography, which includes payment of both the professional and technical components.* |

*In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

## DEFINITIONS

This section provides the meaning of special terms used in this Policy. Whenever the following terms appear capitalized in this Policy, these definitions apply:

**Ambulatory Surgical Center** means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery it must: (1) admit and discharge the patient within the same working day; (2) be supervised by a Doctor; (3) require a licensed anesthesiologist or licensed Certified Registered Nurse Anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

Ambulatory surgical center does not include: (1) a facility whose main purpose is performing terminations of pregnancy; (2) an office maintained by a Doctor for the practice of medicine; or (3) an office maintained for the practice of dentistry.

**[Chemical Dependency** is the pathological use or abuse of alcohol and/or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.]

**Clinical Trials** means Phase II, Phase III, and Phase IV patient research studies designated to evaluate new treatments, including prescription drugs, and that: (1) involve the treatment of life-threatening medical conditions; (2) are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives; and (3) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives. Covered clinical trials must also meet the following requirements:

1. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities; and
3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

**Coinsurance Percentage** is the applicable percentage specified in the Schedule that We will use in computing the amount payable for a benefit.

**Complications of Pregnancy** means: (1) Conditions (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, post hemorrhage, septic pelvic thromboplebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency Cesarean section required because of: (a) fetal or maternal distress during labor, (b) severe pre-eclampsia, (c) arrest of descent or dilitation, (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a Cesarean section delivery is not considered to be an emergency Cesarean section if it is merely for the convenience of the patient and/or Doctor solely due to a previous Cesarean section.

(2) Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditidiform mole; or ectopic pregnancy.

"Complications of Pregnancy" does not include false labor, occasional spotting, Doctor-prescribed rest during the period of pregnancy, morning Sickness, elective Cesarean section, and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy.

**Confined/Confinement** means the time in which a Covered Person is a Registered Bed Patient in a Hospital on the order of a Doctor, for Medically Necessary medical treatment.

**[Covered Dependent** means Eligible Dependents who have become Covered Person(s) under this Policy.]

**Covered Expenses** means: (1) Costs of treatments, services and supplies which a Doctor recommends as Medically Necessary to treat a Sickness or Injury and which in the geographical area where rendered are the Usual, Reasonable and Customary services, supplies and treatment provided for the condition being treated; (2) charges which are Usual, Reasonable and Customary and which the person incurs while he is covered; (3) charges which You or Your Covered Dependent are legally required to pay; and (4) any other charges which are identified as Covered Expenses under the Schedule of Benefits.

**Coverage Period** means the maximum length of time coverage is in force under this Policy. The Coverage Period is shown in the Schedule.

**Covered Person(s)** means You [and Your Covered Dependents]. See the provision entitled Eligibility.

**Deductible** means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. The Deductible is shown in the Schedule.

**Doctor** means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license, including a Doctor's assistant and a licensed marriage and family therapist. "Doctor" does not include You, a Covered Dependent, Immediate Family, or a Covered Person's employer.

**Effective Date** means the date coverage under the Policy begins for a Covered Person. The Effective Date is shown in the Schedule.

**Emergency Services** means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

**Policy** means the contract issued to the Policyholder providing the benefits described herein.

**Home Health Agency** means a public agency or private organization, or a sub-division of such an agency or organization, which:

1. Is primarily engaged in providing skilled nursing services and other therapeutic services;
2. Has policies established by a group of professional personnel (associated with the agency or organization), including one or more Doctors and one or more Nurses, to

govern the services which it provides, and provides for supervision of such services by a Doctor or Nurse;
3. Maintains clinical records on all patients;
4. In the case of an agency or organization in any State, in which State or applicable local law provides for the licensing of agencies or organizations of this nature:
    a. Is licensed pursuant to such law; or
    b. Is approved by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and
5. Meets such other conditions of participation as are established under the Medicare program in the interest of the health and safety of individuals who are furnished services by such agency or organization.

**Home Health Aide** means a person who (1) provides care of a medical or therapeutic nature; and (2) reports to and is directly supervised by a Home Health Agency.

**Home Health Care Plan** means a plan of home-based care which meets these standards: (1) A Doctor has established and approved the plan in writing; and (2) the plan covers a condition which would otherwise require Confinement in a Hospital or convalescent nursing home.

**Home Health Care Visit** means any visit by a member of a home health care team. Each visit by a member of the home health care team other than a Home Health Aide counts as one home health care visit. One visit up to a maximum of four hours of service by a Home Health Aide counts as one home health care visit.

**Hospital** means an institution which is legally constituted and operated in accordance with the laws pertaining to Hospitals in the Jurisdiction where it is located, which meets all of the following requirements:
1. It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
2. It provides 24-hour-a-day nursing service by a Nurse;
3. It is under the supervision of a staff of duly-licensed Doctors; and
4. It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis.

"Hospital" does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor other than incidentally, a place providing care for persons with Mental Illness or Nervous Disorders; the aged, or those suffering from alcoholism or drug addiction.

Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be Confinement in an institution other than a Hospital. A State tax-supported institution will not be excluded, even though it may not have an operating room and related equipment for surgery.

**Immediate Family** means: (1) the parent, spouse, brother, sister or children of a Covered Person (2) a resident in a Covered Person's household; or (3) any person related to a Covered Person by blood, marriage or legal adoption.

**Injury** means bodily harm caused by an accident directly and independently of Sickness or bodily infirmity resulting in unforeseen trauma requiring immediate medical attention The Injury must occur after the Covered Person's Effective Date of coverage and while such person's coverage is in force. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries, shall be considered one injury.

**Intensive Care Unit** means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board and constant observation by a Nurse or other specially-trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

**Lifetime Maximum Amount** is the total aggregate amount of benefits payable under this Policy for all Covered Expenses which are incurred for Sickness or Injury by each Covered Person during such person's lifetime, except as otherwise provided. The Lifetime Maximum Benefit applies to all Covered Expenses, unless indicated otherwise for a specific benefit, and is shown in Your Schedule.

**Medically Necessary** means that the services or supplies are provided for the diagnosis or treatment or relief of a condition, illness, injury or disease; and except as allowed under the Coverage for Clinical Trials, not for experimental, investigation, or cosmetic purposes; are necessary for and appropriate to the diagnosis or treatment and within the accepted community standards of medical care and are not solely for the convenience of the insured, the insured's family or the provider.

**[Mental Illness or Nervous Disorder** means a psychoneurosis, psychosis, eating or personality disorder or panic disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, and determined by the manifestation of symptoms regardless of whether such Mental Illness or Nervous Disorder has a physical or organic basis or origin.]

**Nurse** means a licensed registered graduate professional Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is under the direction of a Doctor. Nurse does not include the Immediate Family of a Covered Person.

**Prescription or Legend Drugs** means: (1) a Legend Drug; (2) injectable insulin prescribed by a Doctor; (3) a compounded drug of which at least one part is a Legend Drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Doctor. "Prescription or Legend Drugs" do not include oral contraceptives for prevention of pregnancy.

**Professional Review Organization** means an organization we select to provide a program of medical review services under Doctors, Nurses and record technicians.

**Registered Bed Patient** means an individual who, while Confined to a Hospital or Skilled Nursing Facility, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

**Sickness** means an Illness, disease, or infection which begins while coverage is in force under this Policy for the Covered Person. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness. Sickness includes Complications of Pregnancy. [With respect to Dependent Children who automatically become insured under the Policy at birth, the term "Sickness" shall also include medically diagnosed congenital defects and birth abnormalities.]

**Skilled Nursing Facility** means an institution, or a distinct part of an institution, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for persons convalescing from Injury or Sickness, and: (1) is approved by and is a participating Skilled Nursing Facility of Medicare; (2) has organized facilities for medical treatment and provides 24-hour a day nursing service under the full-time supervision of a licensed Doctor or Nurse; (3) maintains daily clinical records on each patient and has available

the services of a licensed Doctor under an established agreement; (4) provides appropriate methods for dispensing and administering drugs and medicines; (5) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one licensed Doctor; and (6) is not, other than incidentally, a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

**Total Disability or Totally Disabled** means that You are prevented from engaging in Your own occupation for wage or profit or any occupation to which You are suited by talent or education by reason of Injury or Sickness. [A Covered Person other than You is considered to be Totally Disabled when he is prevented by reason of Injury or Sickness from engaging in all normal activities of a person of like age and sex in good health.]

**Urgent Care Center** means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

**Usual, Reasonable and Customary** means:

1. With respect to fees or charges, fees for medical services or supplies which are:
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received, whichever is less; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

**We, Us, Our or Company** means Starr Indemnity & Liability Company.

**You or Your** (also, **Policyholder**) means the primary insured person who is named in the Schedule as the Policyholder.

## ELIGIBILITY

### I. YOU

You will be eligible for insurance provided:

1. [You are at least 2 years old but under 65 years of age;
2. You are not covered as a dependent under the Policy;
3. You are not pregnant at the time of application;
4. You have a social security number (this does not apply to a minor);
5. You are not an active member of the armed forces;
6. You submit a written application for insurance, provide evidence of insurability, if evidence is required, and meet our enrollment and underwriting requirements; and
7. You pay all required premiums when due.]

### [II. ELIGIBLE DEPENDENTS

**Spouse**: You will be eligible to apply for insurance for Your lawful spouse who:

1. [Is under age 65;
2. Is not pregnant at the time of application;
3. Is not an active member of the armed forces;
4. Has a social security number; and
5. Has provided a written application for insurance and evidence of insurability, if evidence is required, has been approved, and meets our enrollment and underwriting requirements.]

**Dependent Children**: You will be eligible to apply for insurance for your dependent children who:

1. Are unmarried children primarily dependent upon You for support and maintenance; and
2. a. Are less than [19] years or age;
   b. Are at least [19] years of age but less than [25] years and enrolled and attending as a full-time student at an accredited college, university, vocational or technical school;
3. Are not pregnant at the time of application;
4. Are not active members of the armed forces; and
5. Have provided a written application for insurance and evidence of insurability, if evidence is required, have been Approved, and meet Our enrollment and underwriting requirements.

**"Children"** means natural children stepchildren, legally-adopted children, children placed with You for the purpose of adoption, children subject to Your legal guardianship, and a foster child placed in the foster home.

**"Foster child"** means a minor (i) over whom a guardian has been appointed by a court; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

**"Placement in the foster home"** means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

**"Adopted Children"** means, in connection with any adoption or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

**"Placement for adoption"** means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

If You and Your spouse are both Covered Persons, only one parent will be eligible for insurance on any Covered Dependent children You may have.**]**

### III. ENROLLMENT REQUIREMENTS

You [and Your eligible Dependents] who desire coverage must complete and submit an application for the plan and complete or provide any other documents (including evidence of insurability) as we deem necessary. You must submit the required premium with Your application form. Any misrepresentation or omission of Information in Your application or any documents submitted to Us may result in rescission of all coverage for all Covered Persons.

If You are an Insuring Parent, the Company will not deny the enrollment of a child, under this plan, because the child:

1. Was born out of wedlock;
2. Is not a dependent claimed on Your federal income tax; or
3. Does not live with You.

The Company will provide the Noninsuring Parent with claim forms and any other information needed to obtain benefits for the child. The Company will process claims and reimburse the Noninsuring Parent, provider of care, or the appropriate government agency if applicable when the Noninsuring Parent incurs an expense covered by the Policy.

**Insuring Parent** means a parent who is required by court order or administrative order to provide health insurance coverage for a child. **Noninsuring Parent** means a parent other than the Insuring Parent.

### IV. UNDERWRITING REQUIREMENTS

You [and Your Eligible Dependents] are subject to our underwriting requirements. We reserve the right to decline or rate any person at Our discretion.

### V. ADDITIONAL CONDITIONS

Insurance will not be effective unless all eligibility requirements are met and You receive written acceptance from Us. Insurance on a Covered Person will not be effective unless premium is paid and accepted by Us for such insurance. Issuance of a Policy is not a waiver of any of the above conditions.

## EFFECTIVE DATES

### I. YOU [AND ELIGIBLE DEPENDENTS]

[Coverage is effective as of the Effective Date for You [and any Eligible Dependents] who were included in Your initial application, provided that You meet Our eligibility, underwriting and enrollment requirements. Coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "Yes" to any of the medical history questions in the Application. If such person is the Applicant, coverage is automatically declined for all persons included in Your Application].

### [II. NEWLY ACQUIRED DEPENDENT CHILDREN

Coverage for your child or children born after the Effective Date of this Policy will be effective from the moment of birth. Coverage for that child will end 90 days after this automatic Effective Date unless you have made a written request directing us to add the child or children to your coverage. We must receive this notice within 90 days after the child's date of birth.

Coverage for a child whom a petition for adoption ahs been filed, will become effective the the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if coverage is applied for within the 60-days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption.

Any required additional premium must accompany Your notice. A claim form or Hospital bill does not constitute written notice.

Coverage for your child or children will be for Injury or Sickness, including congenital defects, premature birth and tests for hypothyroidism, phenylketonuria, galactosemia, and sickle-cell anemia for a non-Caucasian newborn child. ]

## TERMINATION OF INSURANCE

### I. TERMINATION OF YOUR INSURANCE

Your insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due, if such payment has not been made within 31-days following such premium due date;
2. The [date] [the first day of any policy month] [the anniversary of any premium due date] that insurance under the Policy is discontinued provided the Policyholder received [30-60] day advance written notice;
3. The date that We determine fraudulent statements or a material misrepresentation has been made by You or with Your knowledge in filing a claim for benefits;
4. The date that You enter full-time active duty in the armed forces of any country or international organization;
5. The date You become eligible for Medicare;
6. The earlier of: (1) the Expiration Date of Your coverage; or (2) 12-months from the

Effective Date of Your insurance, whichever occurs first.

**[II. TERMINATION OF A COVERED DEPENDENT'S INSURANCE**

A Covered Dependent's insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due if such premium payment has not been made within 31-days following such premium due date;
2. The [date] [the first day of any policy month] [the anniversary of any premium due date] that insurance under the Policy is discontinued provided the Policyholder received [30-60] day advance written notice;
3. The date that we determine fraud or material misrepresentation has been made by You or a Covered Dependent or with Your or a Covered Dependent's knowledge in filing a claim for benefits;
4. The date that Your insurance terminates. However, if termination is due to Your death, a Covered Dependent may elect to continue coverage beyond the original Expiration Date by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, Your Covered Dependent spouse will be considered the primary insured;
5. The date You or a Covered Dependent becomes eligible for Medicare;
6. The date the Covered Dependent ceases to be eligible. However if, upon attaining any limiting age, a Covered Dependent has a handicapped condition rendering such person incapable of earning his own living and is chiefly dependent upon You or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the limiting age, benefits with respect to such person may be continued on a premium-paying basis during the continuance of such dependency. During the first 2-years that insurance is being continued, we have the right to have the dependent examined at any time by Doctors designated by us. Thereafter, we will not require examination more than once each year. The continuance of insurance as described will cease in the event of:
    a. The termination of the Policy; or
    b. The termination of Your insurance; or
    c. The discontinuance of insurance under the Policy; or
8. The earlier of (i) the Expiration Date shown in the Schedule; or (ii) [12-months] from the Effective Date of Your insurance, whichever occurs first. ]

**III. Termination of the Policy:** The Policy will terminate on the earliest of the following dates:

1. The date the Policyholder elects to terminate the Policy, provided that the Policyholder gives us at least [60 days] advance written notice; or
2. The date there are no Covered Persons under the Policy.

We may terminate the Policy on [the first day of any policy month] [the anniversary of any premium due date] by giving the Policyholder at least [30 days] advance written notice.

**HOSPITAL PRECERTIFICATION**

Hospital admissions and lengths of stay are subject to certification by a Professional Review Organization, as stated below:

1. You must notify the Professional Review Organization on behalf of a Covered Person:
    a. Ten (10) days prior to non-emergency admission of the Covered Person to a Hospital;
    b. Within 48-hours from the time the Covered Person is in stable condition following an emergency admission*, or as soon thereafter as is reasonably possible if the Covered Person's medical condition prevents or delays such notification; or
    c. Within 48-hours of normal delivery (96 hours for cesarean section) for complicated birth or as soon as reasonably possible.

*A person is covered for Emergency Medical Conditions and may receive medical services to treat an Emergency Medical Condition without prior authorization if a prudent layperson acting reasonably would have believed that an Emergency Medical Condition existed. In order to ensure that a person receives proper care for their condition, the person should call the Professional Review Organization and inform them of their condition and the services they are receiving.

When prior authorization has been given for Emergency Services, the Company will cover the services and will not retract the authorization after the services have been provided unless the authorization was based on material misrepresentation about the Covered Person's health condition.

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic condition that would lead a prudent layperson possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any body organ or part.

2. The Professional Review Organization, after reviewing the applicable information, will certify:
   a. If the Hospital admission is Medically Necessary;
   b. The appropriate length of stay; and
   c. Appropriate extensions beyond the initially-certified length of stay.

3. **REDUCTION OF BENEFITS:** If Covered Expenses for the Hospital admission, length of stay, or extensions of stay are not certified by the Professional Review Organization, We will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. No benefits will be payable in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary.

## DESCRIPTION OF BENEFITS

### I. WHAT IS COVERED

Subject to the Hospital Precertification provision, if You [or a Covered Dependent] incurs Covered Expenses for medical treatment supplies or services as a result of a Sickness or Injury which occurs while coverage is in force, and after satisfaction of the Deductible, We will pay the Coinsurance Percentage for Covered Expenses incurred in excess of the Deductible. We will pay this amount for all Covered Expenses unless otherwise noted for a specific benefit or specified as limited or excluded in the Limitations and Exclusions provision.

After Covered Expenses for which benefits are payable at the Coinsurance Percentage have equaled the Coinsurance Limit for a Covered Person, We will pay Covered Expenses in excess of the Coinsurance Limit at the amount shown in the Schedule for each such person while coverage is in force, but not to exceed the Lifetime Maximum Amount payable for each Covered Person.

The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount are shown in Section I of the Schedule and apply to each Covered Person and for all benefits, unless otherwise stated for a specific benefit in Section II of the Schedule.

## II. COVERED EXPENSES

**Covered Expenses** mean the Usual, Reasonable and Customary charges for the following Medically Necessary services, supplies, or treatment prescribed or provided by a Doctor for a covered Injury or Sickness while coverage is in force for a Covered Person. The Company reserves the right to interpret and determine coverage for Covered Expenses. The fact that a Doctor has prescribed, recommended, approved, or provided a treatment, service or supply does not, in itself, make such treatment, service or supply a Medically Necessary covered expense.

### A) HOSPITAL COVERED EXPENSES

1. **Hospital Room, Board and General Nursing Care:** While Confined in a Hospital, the Coinsurance Percentage for the average daily charge for room and board in a semiprivate room with at least two beds. If the Hospital does not have semiprivate rooms available, the Coinsurance percentage will be based on the daily charge for room and board for the Hospital's lowest rate private room. If a facility contains only private rooms, coverage will be limited to the Coinsurance Percentage shown in the Schedule for a private room.

2. **Intensive or Specialized Care Unit:** Provided four or more hours of nursing care is being provided each day, the Coinsurance Percentage for each day of Confinement, up to 3 times the average semi-private room rate. If the Hospital does not have semiprivate rooms available, the amount payable will be 3 times the daily charge for room and board at the Hospital's lowest rate private room.

3. **Emergency Room Treatment**: The Coinsurance percentage for services, supplies and treatment.

4. **Miscellaneous Medical Services:** The Coinsurance Percentage for services and supplies provided on an inpatient basis in a Hospital. Miscellaneous charges do not include charges for a telephone, radio, television, extra beds or cots, meals for guests, take home items, or other items of convenience.

5. **Outpatient Hospital Services:** The Coinsurance Percentage for charges made by a Hospital when received on an outpatient basis, excluding professional services.

### B) COVERED EXPENSES FOR TREATMENT

1. **Doctor Services:** The Coinsurance Percentage for treatment provided by a Doctor. This benefit is not payable for treatment provided by a member of your Immediate Family.

2. **Therapist Services:** The Coinsurance Percentage for treatment provided by a therapist for diagnosis and rehabilitative treatment. This benefit is not payable for treatment provided by a member of your immediate family.

### C) OTHER COVERED EXPENSES

1. **Ambulatory Surgical Center [or Outpatient Hospital Surgery]:** The Coinsurance Percentage for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital [or a Hospital Outpatient Surgery Facility].

2. **Anesthetics:** The Coinsurance Percentage of the amount payable to the Doctor performing the surgery for anesthetics and their administration. The Coinsurance Percentage specific to this benefit is shown in the Schedule. This includes coverage for payment of anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

3. **Assistant Surgeon:** The Coinsurance Percentage of the amount payable to the Doctor performing the surgery for a Doctor assisting in the performance of a surgery. The Coinsurance Percentage specific to this benefit is shown in the Schedule.

4. **Surgeon's Assistant:** The Coinsurance Percentage of the amount payable to the Doctor performing the surgery for a Doctor assisting such Doctor. The Coinsurance Percentage specific to this benefit is shown in the Schedule.

5. **Blood or Blood Plasma:** The Coinsurance Percentage, if not replaced.

6. **Artificial Limbs or Eyes:** The Coinsurance Percentage.

7. **Casts, Non-Dental Splints, Trusses, Crutches, or Non-Orthodontic Braces:** The Coinsurance Percentage.

8. **Equipment Rental:** The Coinsurance Percentage for a wheelchair, hospital-type bed or similar durable medical equipment, not to exceed the purchase price of such equipment.

9. **Oxygen:** The Coinsurance Percentage for oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment.

10. **Complications of Pregnancy:** Treatment for Complications of Pregnancy on the same basis as any other Sickness.

11. **X-Ray and Laboratory Tests:** The Coinsurance Percentage for X-Ray and laboratory on an outpatient basis.

12. **[Prescription or Legend Drugs:** The Coinsurance Percentage when prescribed on an inpatient basis for a Covered Injury or Sickness.]

13. **Dental Treatment:** The Coinsurance Percentage for treatment or care required as a result of a Covered Injury to a tooth that is natural, free of disease, and vital where the major portion of the tooth is present regardless of fillings or caps.

14. **[Cosmetic or Reconstructive Surgery (Except Breast Reconstructive Surgery):** The Coinsurance Percentage for cosmetic or reconstructive surgery and complications of cosmetic procedures when services and treatment are:

    a. Incidental to or follows a Covered Injury or Sickness occurring while this coverage is in force; or

    b. Performed due to a congenital defect or birth anomaly of a Covered Person born while this coverage is in force, including but not limited to the necessary care and treatment needed for individuals born with a cleft lip and cleft palate, of a newborn child, foster child or adopted child.]

15. **Breast Reconstructive Surgery:** The Coinsurance Percentage for a female Covered Person who undergoes a covered mastectomy surgery while such person's coverage under this Policy is in force. Benefits payable include:

    a. Reconstructive surgery of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast for the purpose of obtaining a symmetrical appearance; and

    c. Prostheses and for treatment for physical complications related to the mastectomy.

16. **Mammography:** The Coinsurance Percentage for low-dose screening mammography as follows, not to exceed the Maximum Benefit Amount shown in the Schedule:

    a. One or more mammograms a year, as recommended by a Doctor, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

        i. The woman has a personal history of breast cancer;

        ii. The woman has a personal history of biopsy-proven benign breast disease;

        iii. The woman's mother, sister, or daughter has or has had breast cancer; or

        iv. The woman has not given birth prior to age 30;

    b. One baseline mammogram for any woman 35 through 39 years of age, inclusive;

    c. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Doctor; and

    d. A mammogram every year for any woman 50 years of age or older.

    e. diagnostic mammography at any age when prescribed by the woman's Doctor.

    Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's Doctor.

    "Diagnostic mammography" means a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the Doctor interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Doctor to correlate the radiologic findings is often performed as part of the study.

    These charges are [not] subject to the Deductible.

17. **Clinical Trials:** Charges for participation in Phase II, Phase III, and Phase IV-covered Clinical Trials who meet protocol requirements of the trials and provide informed consent. Only Medically Necessary costs associated with participation in a covered clinical trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and

medically necessary monitoring will be covered and only to the extent that such costs have not been or are not funded by the national agencies, commercial manufacturers, distributors, or other research sponsors of participants in Clinical Trials. This provision will not cover: (a) non-FDA approved drugs provided or made available to an insured who received the drug during a covered clinical trial after the clinical trial has been discontinued; (b) services that are not health care services; (c) services provided solely to satisfy data collection and analysis needs; (d) services related to investigational drugs and devices; and (e) services that are not provided for the direct clinical management of the patient. The Company can deny any claim where covered services under this provision and non-covered services are not separated.

18. **Temporomandibular:** The Coinsurance Percentage for procedures involving any bone or joint of the jaw, face, or head, so long as the procedure is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic Injury. Authorized therapeutic procedures include splinting and the use of intraoral prosthetic applies to reposition the bones. However, this does not include coverage for orthodontic braces, crowns, dentures, treatment for periodontal disease, dental root form implants or root canals.

19. **Diabetic Benefit:** The Coinsurance Percentage for medical coverage for Medically Necessary equipment, supplies, and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a Doctor.

    Self-management training shall include coverage for one (1) per lifetime training program per insured for diabetes self-management training when Medically Necessary as determined by a Doctor and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training. In addition to the one (1) lifetime training program, additional diabetes self-management training may be provided in the event that a Doctor prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the insured's symptoms or conditions. A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a Doctor.

    Diabetes Self-Management Training means instruction in an inpatient or outpatient setting, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs which the primary purpose is weight reduction, when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association.

20. **Ambulance:** Up to the Maximum Benefit amount shown in the Schedule for this benefit for local licensed ground ambulance service or air ambulance service within the 48 contiguous states to the nearest Hospital qualified to treat the covered Injury or Sickness. Such service must be Medically Necessary due to a sudden and unexpected Injury or Sickness that involves a life-threatening element.

21. **Routine Child Health Care:** The Coinsurance Percentage for 20 visits at the approximate age intervals of: birth; 2 weeks; 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months; 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years, that include a history, a physical examination, a development assessment, anticipatory guidance and appropriate immunizations and laboratory tests consistent with the Recommendations of Preventative Pediatric Health Care of the American Academy of Pediatrics from the moment of birth to age 18. These charges, with the exception of immunizations, are subject to the Deductible.

22. **[Organ or Tissue Transplants:** The Coinsurance Percentage for an organ or tissue transplant, up to the Lifetime Maximum Amount shown in the Schedule for this benefit. This benefit shall include all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, including the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

    Covered Expenses do not include organ or tissue transplants which:

    a. Are animal-to-human transplants;

    b. Use artificial or mechanical organs;

    c. Are Experimental or Investigative; or

    d. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness].

23. **Home Health Care:** Charges for home health care, up to the Maximum Benefit Amount and for the Maximum Benefit Period shown in the Schedule for this benefit, for the following:

    a. Part-time or intermittent home nursing care by, or under the direction of, a graduate registered Nurse (RN);

    b. Part-time or intermittent Home Health Aide services that consist only of care for the Covered Person and which are Medically Necessary, as part of the Home Health Care Plan. The services must be under the direction of a Nurse or social worker;

    c. Physical, respiratory, occupational, or speech therapy performed by a licensed therapist for rehabilitative treatment;

    d. Nutrition counseling provided by or under the direction of a registered dietician as part of the Home Health Care Plan; or

    e. The evaluation of the need for and development of a plan by a Doctor, Nurse or social worker. Such services must be requested by the Doctor and approved by us. Review of Medical Necessity may be periodically required.

24. **Skilled Nursing Facility Confinement:** Daily charges for room and board while a Covered Person is confined as a registered bed patient in the facility. The Maximum Benefit Amount and Maximum Days for this benefit are shown in the Schedule. Such Confinement must: (i) start within 14 days after the end of a covered Hospital Confinement of at least 3 continuous days; and (ii) be ordered by a Doctor to convalesce from an Injury or Sickness that caused the prior Hospital Confinement.

25. **Hospice Care:** Hospice care and services incurred for a terminally ill Covered

Person with a life expectancy of 6 months or less, up to the Maximum Benefit Amount shown in the Schedule for this benefit. Covered Expenses include charges incurred for care and services when provided by an agency licensed or certified to provide hospice services, including the following:

a. Part-time or intermittent home nursing care by, or under the direction of a Nurse;

b. Physical, respiratory or speech therapy performed by a licensed therapist;

c. Nutrition counseling provided by or under the direction of a registered dietitian; and

d. Counseling by a licensed social worker, pastoral counselor for the Covered Person or a member of the Immediate Family, the primary care giver and individuals with significant personal ties to a Covered Person who is terminally ill.

Hospice services must be:

a. Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and

b. Provided only if the Doctor submits written certification to Us that the Covered Person is terminally ill with a life expectancy of 6 months or less. Review of Medically Necessity may be periodically required.

This benefit does not include the services of volunteers or persons who do not regularly charge for their services.

26. **AIDS:** The Coinsurance Percentage for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or any complication or condition caused by, resulting from or related to AIDS or HIV, up to the Lifetime Maximum Amount shown in the Schedule for this benefit.

27. **[Foreign Travel:** After satisfying the Deductible specific to this benefit, We will pay the Coinsurance Percentage for medical care while in a foreign country, up to the Lifetime Maximum Amount shown in the Schedule for this benefit. The Covered Person's primary residence must be in the United States and treatment rendered for an Injury or the sudden and unexpected onset of a Sickness requiring immediate medical attention and be provided within [the first 90 days] of the Covered Person's trip outside the United States. The Deductible for this benefit is shown in the Schedule**]**.

28. **[Knee Injury or Disorder**: The Coinsurance Percentage payable for the treatment of Knee Injury or disorder. This does not include charges incurred to diagnose or treat an Injury or disorder of the knee including surgery in excess of the Knee Injury or Disorder Maximum shown in the Schedule. The knee consists of the bones, muscles, cartilage, ligaments, membranes and menisci of the anterior aspect of the leg at the articulation of the femur and tibia.]

29. **[Gallbladder Surgery**: The Coinsurance Percentage for surgery for cholecystectomy and any type of surgical procedure to diagnose or treat a disorder of the gallbladder, including any condition related to or caused by a gallstone(s) in the bile duct. Surgery includes the pre-operative and post-operative visits, testing, the services of the surgeon, assistance surgeon, anesthesiologist, radiologist, pathologist, the Hospital or outpatient facility

charges, and any other charges related to the surgery or complications therefrom. Expenses do not include charges incurred in excess of the Gallbladder Surgery Maximum shown in the Schedule. ]

30. **Loss or Impairment of Speech or Hearing:** The Coinsurance Percentage for the Medically Necessary diagnosis and treatment of loss or impairment of speech or hearing. Covered Expenses for such treatment will be paid as they would for any other Sickness. No benefits will be paid for hearing instruments or devices. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

31. **Colorectal Cancer Exams and Lab Tests:** The Coinsurance Percentage for the following colorectal cancer examinations and laboratory tests: (1) an annual fecal ocular blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; (2) a double-contrast barium enema every five years; (3) a colonoscopy every ten years; and (4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, subject to the guidelines for the management or subsequent need for follow-up colonoscopy.

    These benefits will be covered for a Covered Person who is: (1) fifty years of age or older; (2) less than fifty years of age and a high risk for colorectal cancer according to the current American Cancer Society colorectal cancer screening guidelines; and (3) experiencing the following symptoms of colorectal cancer as determined by a Doctor: (a) bleeding from the rectum or blood in the stool; or (b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

32. **Medically Necessary Foods:** The Coinsurance Percentage for medical foods and low protein modified food products for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if:
    a. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
    b. The products are administered under the direction of a Doctor;
    c. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars ($2,400) per year per person allowed under Arkansas law.

    This includes coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a Doctor for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

33. **Prostate Cancer Screening**: The Coinsurance Percentage for screening for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines and performed by a qualified medical professional. If a medical practitioner recommends that an insured, undergo a prostate specific antigen blood test, coverage may not be denied on the ground that the insured has already had a digital rectal examination and the examination result was negative. These

charges are not subject to the Deductible.

34. **[Hearing Aids**: The Coinsurance Percentage for coverage for a hearing aid or hearing instrument sold by a professional licensed by the state to dispense a hearing aid or hearing instrument, not to exceed one thousand four hundred dollars ($1,400) per beginning on the first day of coverage. These charges are not subject to the deductibles or any copayment requirements.]

35. **In Vitro Fertilization**: The Coinsurance Percentage for in vitro fertilization services performed at a medical facility certified by the Department of Health, or a facility certified as conforming to the American College of Obstetricians and Gynecologists Guidelines for In Vitro Fertilization, or which meets the American Fertility Society standards.

36. **Hospital Newborn Coverage:** The Coinsurance Percentage for routine nursery care and pediatric charges for up to five (5) full days in a Hospital nursery or until discharge of the mother of the newborn from the Hospital following the birth of the child, whichever is the later; and any testing of a newborn child hereafter mandated by law.

## III. ALLOCATION AND APPORTIONMENT OF BENEFITS

We reserve the right to allocate the Deductible to any Covered Expenses and to apportion the payment of benefits between You and any person designated by You. Such allocation and apportionment shall be conclusive and shall be binding upon You and all assignees.

## IV. EXTENSION OF COVERAGE

If You [or Your Covered Dependent] [is][are] Totally Disabled and receiving benefits for a Hospital Confinement on the date that this Policy terminates [or such dependents coverage under this Policy terminates], benefits will continue in accordance with the terms of this Policy for as long as that Confinement remains continuous and You [or Your Covered Dependent] [is][are] Totally Disabled by reason of such Injury or Sickness. However, in no event will coverage continue beyond the end of the [60 days] following the date coverage ends or the Expiration Date of the Covered Person's coverage. Benefits payable after the Expiration Date or when a Covered Person's coverage ends are subject to a new Deductible and satisfaction of the Coinsurance Limit.

## LIMITATIONS AND EXCLUSIONS

We will not pay for loss or expense caused by or resulting from any of the following:

1. [Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision;]
2. [Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated. except in accordance with the Extension of Benefits provision;]
3. [Expenses to treat complications resulting from treatment of conditions which are not covered under the Policy. This does not include Emergency Services as defined;]
4. [Experimental or Investigative services or treatment. "Experimental or Investigative" means services, supplies, devices, treatments, procedures, or drugs that have no been recognized as generally accepted medical treatments. Our determination of what constitutes Experimental or Investigative treatment will be based on, but not limited to, the approval of treatments from the American Medical Association, the U.S. Food and Drug Administration, and the Administrative Procedure Act. Experimental or Investigative

includes treatments that have not been demonstrated through sufficient peer-reviewed medical literature to be safe and effective for the proposed use;]

5. [Expenses for purposes determined by Us to be educational, except when specifically covered;]
6. [Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies;]
7. [Expenses You [or Your Covered Dependent] are not required to pay, or which would not have been billed, if no insurance existed;]
8. [Expenses to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan;]
9. [Charges that are eligible for payment by Medicare or any other government program except Medicaid;]
10. [Costs for care in government institutions unless You [or Your Covered Dependent] are obligated to pay for such care;]
11. [Expenses for the treatment of an occupational Injury or Sickness which are paid under any Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under any Workers' Compensation ;]
12. [Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited);]
13. [Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to You on a pro rated basis;]
14. [Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;]
15. [Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault;]
16. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy;
17. [Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital except as specifically covered under the Policy, This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth;]
18. [Charges for voluntary termination of normal pregnancy, normal childbirth or elective cesarean section;]
19. [The cost of any drug, including birth control pills, supply, treatment or procedure that prevents conception or childbirth;]
20. [Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate;]
21. [Expenses for sterilization or reversal of sterilization;]
22. [Services, supplies or treatment related to sex transformation or sex dysfunction or inadequacies;]
23. [Costs for physical exams or other services not needed for medical treatment, except as specifically covered;]
24. [Expenses for prophylactic treatment, including surgery or diagnostic testing, except as

specifically covered;]

25. [Expenses for the treatment of Mental Illness or Nervous Disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind, unless specifically covered;]
26. [The costs of treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction, unless specifically covered;]
27. [Expenses incurred in the treatment of Injury or Sickness sustained by voluntary use of alcohol, illegal drugs or hallucinogenics;]
28. [The cost of programs, treatment, or procedures for tobacco use cessation;]
29. [Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, whether while sane or insane;]
30. [The cost of dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered;]
31. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, except as specifically covered;
32. [Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to asses the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts;]
33. [The costs for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids except as specifically covered;]
34. [The costs of cosmetic or reconstructive procedures, services or supplies, except as specifically covered;]
35. [Charges for breast reduction or augmentation or complications arising from these procedures;]
36. Outpatient Prescription or Legend Drugs, medications, vitamins and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor;
37. [The cost of any drug or other item used to treat hair loss;]
38. [Expenses incurred in the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person;]
39. [Expenses incurred in the treatment of acne or varicose veins;]
40. [The costs of weight loss programs, diets, or treatment of obesity;]
41. [Transportation charges, except as specifically covered;]
42. [Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital, unless specifically covered;]
43. [Costs of services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing,

dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops, except as specifically covered;]

44. [Costs of services or supplies furnished or provided by a member of Your Immediate Family;]
45. [Expenses for diagnosis or treatment of a sleeping disorder;]
46. [Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests;]
47. [Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator);]
48. [The costs of services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits;]
49. [Expenses for surgery during the first 6 months after the Effective Date of Coverage for a Covered Person for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis or carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-Existing Conditions exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, herniorraphy, or cholecystectomies;]
50. [Knee Injury or Disorder: Expenses do not include charges incurred to diagnose or treat an Injury or disorder of the knee including surgery in excess of the Knee Injury or Disorder Maximum shown in the schedule;]
51. [Gallbladder Surgery: Expenses do not include charges incurred in excess of the Gallbladder Surgery Maximum shown in the Schedule;]
52. [Participating in [Interscholastic] [Intercollegiate] [Organized Competitive] Sports;
53. [Medical care, treatment, services, or supplies received outside of the United States or its possessions;]

## PRE-EXISTING CONDITIONS LIMITATION

We will not provide benefits for any loss caused by or resulting from, a Pre-Existing Condition.

**"Pre-Existing Conditions"** mean any medical condition or Sickness for which medical advice, care, diagnosis, treatment, consultation, or medication was recommended by or received from a Doctor within the [24 months - 5 years] immediately prior to a Covered Person's Effective Date of Coverage. [This does not apply to congenital birth defects or anomalies of newborn infants, foster children and adopted children when you have paid the additional premium within 30 days of acquiring such dependent.]

**"Consultation"** means evaluation, diagnosis or medical advice was given with or without the necessity of a personal examination or visit.

## CLAIM PROVISIONS

**Notice of Claim:** When a claim arises, the claimant should notify Us or Our authorized administrator or Our authorized agent of the Loss in writing. This written notice of claim must be given within [20] days after commencement of any Loss, or as soon as reasonably possible.

**Claim Forms**: After receiving notice of claim, We or Our authorized administrator will furnish the claimant with a claim form for filing proof of Loss. If this form is not received within [15 days] after

notice has been given, the claimant should submit written proof which covers the occurrence, the character, and the extent of the Loss for which claim is made.

**Proof of Loss:** The claimant must furnish Us or Our authorized administrator with written proof of Loss within [180 days] of the Loss. Where this Policy provides for payments contingent upon a period of Confinement, these [180 days] shall begin at the end of the period for which We are liable. If the claimant does not furnish proof within [180 days] as required, benefits shall still be paid for that loss if: (1) it was not reasonably possible to give proof within those [180 days]; and (2) proof is furnished as soon as reasonably possible and, except in the absence of legal capacity no later than 1 year after the end of those [180 days].

**Time of Payment of Claims:** We will make payment within 30 days upon receipt of due written proof of loss.

**Payment of Claims:** Payment will be made directly to You or the provider of the service, as directed by You in writing at the time of submitting proof of Loss. If You are deceased or, in Our opinion, are Incapable of giving a valid receipt for payment and if no claim has been made by a duly-appointed legal representative, We shall have the option of making payment to either: (1) the Hospital or the person who actually incurred the loss for which payment is due; or (2) Your surviving relative. Such a payment shall discharge Us from all further liability to the extent of the payment made. If any payment payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay an amount not exceeding [$3,000] to any relative by blood or connection by marriage of the Insured or beneficiary deemed to be equitably entitled. Such a payment shall discharge the Company for all further liability to the extent of the payment made.

**Appeal of Claim Denial:** If a claim is denied, You will receive written notice giving the reason for the denial. If You wish to appeal the denial of the claim, such appeal must be submitted to us in writing within [60 days] from the date of notice. You must clearly state the reason You believe the claim decision is incorrect.

**Right of Reimbursement:** If a Covered Person receives a benefit payment from a third party by judgment, settlement, compromise, or otherwise for an Injury or Sickness and we have paid benefits for the same Injury or Sickness, we reserve the right to be reimbursed from the third party in an amount equal to the amount we paid to the Covered Person, the Covered Person's parents (if the Covered Person is a minor), or the Covered Person's legal representative.

You must agree to furnish any information and assistance, or provide any documents that we may reasonably require in order for us to exercise our right of recovery, regardless of whether or not the third party admits liability, Any payment we make by mistake for a work-related Injury must be reimbursed to us when the Covered Person receives payment for such Injury from another source.

It will be assumed that the Covered Person is in receipt of the benefit payment unless such person gives us proof that payment of benefits was denied.

## GENERAL PROVISIONS

**Amendment:** We may amend or change the Policy at any time by giving written notification to the Policyholder. Insurance provided by the Policy may be amended changed or canceled without the consent of any Covered Person.

**Assignment and Claims of Creditors:** Except as provided below, benefits are not assignable. Except as otherwise provided by law, benefit payments may be exempt from legal process for debts or liabilities of a Covered Person. You may direct us to pay benefits to the person or institution on whose charges any claim is based. Any such payment that We make will fully discharge Us to the extent of the payment.

**Changes in Benefits:** Changes in the benefits of a Covered Person will apply only to Covered Expenses or losses incurred after the effective date of the change.

**Clerical Error:** Clerical errors that We or Our authorized administrator make in Your Schedule of benefits, the issuance of a Policy, or in record keeping will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to offset or recover from You any overpayment of benefits made due to such errors.

**Conformity With Statutes:** Any provision of this Policy that is in conflict with the statutes of the jurisdiction in which the Policyholder is located on such date is hereby amended to conform to the minimum requirements of such statutes.

**Contract/Changes:** The effective time for any dates used shall be 12:01 A M. Standard Time at the address of the Policyholder.

**Entire Contract:** The entire contract consists of the Policy, Your application form and any other documents requested and accepted by Us. No change in the Policy or Your coverage is valid unless approved by Our Executive Officer. Such approval must be signed by Our Executive Officer and attached to the Policy. No broker, agent or producer can change or waive any provision of the entire contract or any of Our requirements.

**Grace Period:** You have a 31-day Grace Period for the payment of each premium due after the first premium. Your coverage will continue in force during the Grace Period unless You have given Us prior written notice of termination. If such a premium is not paid by the end of the Grace Period, all such insurance will end as of the due date of such premiums, and no expenses incurred during the Grace Period will be considered for benefits.

**Incontestability:** All statements You make will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest unless You have been given a copy. Any misstatement or omission of information made on Your application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis for later rescission of coverage. After coverage for a Covered Person has been in force for 3 years during the Covered Person's lifetime, We do not have the right to contest coverage, except for fraud or non-payment of premium.

**Legal Proceedings:** No proceedings to obtain benefits may be brought against Us until 60 days after We have received proper written proof of Loss and any other documentation necessary to establish the benefits due. No proceedings may be brought more than 3 years after proof is required to be filed.

**Physical Exam and Autopsy:** We may require, at Our expense, medical examinations of any person for whom claim is made when and as often as it may reasonably require during the pendency of a claim. [We may also make an autopsy. if not forbidden by law].

**Premium Payments:** All premiums are paid to Us, or, if We direct, to Our authorized administrator. The first premium is due on the Effective Date. Subsequent premiums are due [monthly], in advance, on the anniversary day and month of the Effective Date. Except as

otherwise provided herein, all such insurance will terminate on the premium due date, except as provided in the Grace Period provision, if premiums are not paid when due.

**Premium Changes:** We will determine the premium for each Covered Person. We have the right to change premium rates on any premium due date by giving You [45 days] advance written notice of such change. The premium rates will not be changed more often than once every 12 months after the first Policy anniversary date.

**Pronouns:** Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also unless the context clearly indicates to the contrary.

**Rescission:** A misrepresentation or omission in the application form or other documents provided to Us may be the basis for later rescission of all coverage of all persons covered under the Policy. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims We paid.

**Workers' Compensation:** This Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

**Misstatement of Age:** If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

**Reinstatement:** If any renewal premium is not paid within the time granted the Covered Person for payment, a subsequent acceptance of premium by the Company without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

**Refund of unearned premiums upon death of insured.** Upon the death of the Covered Person, the proceeds payable to the insured or his or her estate under the Policy shall include premiums paid for any period beyond the end of the Policy month in which the death occurred. The unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the Covered Person's death has been furnished to the Company.

# Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: [399 Park Avenue, 8th Floor, New York, New York 10022]
(hereafter referred to as "we," "us," and "our")

## SHORT TERM MEDICAL INSURANCE POLICY

| | |
|---|---|
| **[POLICYHOLDER:** | [John Doe] |
| **POLICY NUMBER:** | [12345] |
| **COVERAGE PERIOD:** | [6] Months |
| **EFFECTIVE DATE**: | [07-01-09] |
| **EXPIRATION DATE:** | [12-31-09] ] |

## SCOPE OF COVERAGE

**POLICY ISSUED TO THE POLICYHOLDER IN THE STATE OF ARKANSAS.**

This Policy is issued and delivered in the State shown above and shall be governed by its laws.

This Policy is the contract between the Policyholder and Starr Indemnity & Liability Company. This Policy contains the terms under which we agree to insure eligible persons and pay benefits, subject to the terms and conditions herein. References to Covered Dependents insurance apply only if You have elected such coverage. Coverage under this Policy is provided in consideration of payment of the initial premium and continued payment of premiums when due and that the answers in Your application are correct and complete.

**[10 DAY RIGHT TO RETURN THE POLICY**
If for any reason you are not satisfied with this Policy, you may return it to us within 10 days after you receive it. We will refund any premium paid and the Policy will be deemed void, just as though it had not been issued**]**.

**THIS POLICY IS NON-RENEWABLE TERM INSURANCE.**
**IT WILL NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD.**
**READ IT CAREFULLY.**

Signed for Starr Indemnity & Liability Company By:

[Honora M. Keane], General Counsel

[Charles H. Dangelo], President

**Policyholder Service Office of Company:** Starr Indemnity & Liability Company
**Address:** [399 Park Avenue, 8th Floor, New York, NY 10022], **Telephone:** [1-800-XXX-XXXX]

If we at Starr Indemnity & Liability Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
Little Rock, AR 72204
(501) 371-1811

**TABLE OF CONTENTS**

The following provisions appear within this Policy in the following order:

## SCHEDULE

### PRE-ADMISSION CERTIFICATION NOTICE

This plan requires a Pre-Admission Certification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours from the time the person is in stable condition following an emergency admission, or as soon as reasonably possible if the person's medical condition prevents or delays such notification; or
3. Within 48-hours of delivery (96 hours for cesarean section) for complicated childbirth or as soon as reasonably possible.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%,** unless the Covered Person is incapacitated and unable to contact Us in such cases, the Covered Person must contact Us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.

## SECTION I

**The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount apply to each Covered Person and for ALL benefits, unless otherwise stated for a specific benefit in SECTION II.**

**THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON**

| | |
|---|---|
| **DEDUCTIBLE**: | [$250 - $10,000] |

[When [4] insured individuals in a family satisfy their Deductibles, the Deductibles for any remaining insured individual in the insured family are deemed satisfied for the remainder of the Coverage Period.]

| | |
|---|---|
| **COINSURANCE:** | |
| Coinsurance Percentage: | [50 - 100]% up to the Coinsurance Limit |
| Coinsurance Limit: | [$5,000-$20,000] |
| Thereafter | [80%-100%] |
| **LIFETIME MAXIMUM AMOUNT:** | [$500,000 - $2,000,000] |

## SECTION II

## MAXIMUM BENEFITS FOR EACH COVERED PERSON:

| | |
|---|---|
| **HOSPITAL COVERED EXPENSES:** | |
| **In Hospital Coinsurance Percentage** | [50 - 100%] [not to exceed [$1,000] per day including all miscellaneous medical charges**] |
| **In Hospital Intensive or Critical Care** | [50 - 100%] [not to exceed [$1,250] per day including all miscellaneous medical charges**] |
| **OTHER COVERED EXPENSES:** | |
| **Ambulatory Surgical Center [or Outpatient Hospital Surgery]:** | [50 - 100%] [not to exceed $1,000] per day including all miscellaneous medical expenses**] |
| **[Out-Patient Emergency Room:** This includes the emergency room physician charge, 24 hours surveillance and all miscellaneous medical charges**. | [50 - 100%] [not to exceed $500] per day**]** |

[**Miscellaneous medical charges include: X-rays, scans, laboratory, blood, therapy, oxygen, casts, splints, medicines, injections, chemotherapy and medical supplies.]

| | |
|---|---|
| **Anesthetics Coinsurance Percentage:** | [50 - 100%] up to [20%] of the surgeon's benefit |
| **Assistant Surgeon Coinsurance Percentage:** | [50 - 100%] up to [20%] of the surgeon's benefit |
| **Surgeon's Assistant Coinsurance Percentage:** | [50 - 100%] up to [20%] of the surgeon's benefit |

[The Surgeon, Anesthetics, Assistance Surgeon and Surgeon's Assistants benefits are limited to [$2,500] per surgery, for all Covered Expenses combined, not to exceed [$5,000] per Coverage Period.]

| | |
|---|---|
| **[In Hospital Doctor Visits**: | [50 - 100%] [not to exceed $500] per Hospital stay. **]** |
| **[Outpatient Miscellaneous Charges**: This does not include outpatient Hospital surgery | [50 - 100%] not to exceed [$1,000] per coverage period for all Covered Expenses combined. **]** |
| **Doctor's Office and Urgent Care Center:** | [For each visit after a [$50] copayment, not to exceed a maximum of [3] visits per Coverage Period. The first [3] visits are not subject to the Deductible. Visits in excess of the maximum of [3] visits per Coverage Period will be subject to the Deductible and Coinsurance.]<br><br>*OR*<br><br>[Up to [$25] per visit not to exceed [4] visits per Coverage Period. The balance of the office visit expense will be payable |

| | |
|---|---|
| | subject to the Deductible and Coinsurance, not to exceed [$1,000] per coverage period.] |
| **Skilled Nursing Facility:** | |
| Maximum Benefit Amount: | [$30] per day |
| Maximum Days: | [30] days per Coverage Period |
| **Ambulance Ground or Air:** | |
| Maximum Benefit: | [$250] per trip |
| **Home Health Care:** | |
| Maximum Benefit Amount: | [$40] per visit |
| Maximum Benefit Period: | [40] visits per Coverage Period |
| **Hospice Care:** | |
| Maximum Benefit: | [$5,000] per Coverage Period |
| **[Acquired Immune Deficiency Syndrome (AIDS)** | [$10,000] per Coverage Period |
| **[Knee Injury or Disorder:** | |
| Lifetime Maximum Benefit: | [$2,500] per Covered Person [for both left knee and right knee] [per left or right knee] ] |
| **[Gallbladder Surgery:** | |
| Lifetime Maximum Benefit: | [$2,500] per Covered Person ] |
| **[Organ, Tissue Transplants:** | |
| Lifetime Maximum Benefit for all Covered Expenses | [$50,000 - $150,000] per Covered Person] |
| **[Foreign Travel:** | |
| Foreign Travel Deductible: | [$250] per Covered Person |
| Lifetime Maximum Benefit: | [$25,000] per Covered Person] |
| **Temporomandibular Joint Disorder (TMJ):** | |
| Lifetime Maximum Benefit for authorized therapeutic procedures and Procedures for non-surgical treatment for TMJ: | [$3,500] per Covered Person |
| **Mammography** | |
| Maximum Benefit | [$50] for each screening mammography, which includes payment of both the professional and technical components.* |

*In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

## DEFINITIONS

This section provides the meaning of special terms used in this Policy. Whenever the following terms appear capitalized in this Policy, these definitions apply:

**Ambulatory Surgical Center** means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery it must: (1) admit and discharge the patient within the same working day; (2) be supervised by a Doctor; (3) require a licensed anesthesiologist or licensed Certified Registered Nurse Anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

Ambulatory surgical center does not include: (1) a facility whose main purpose is performing terminations of pregnancy; (2) an office maintained by a Doctor for the practice of medicine; or (3) an office maintained for the practice of dentistry.

**[Chemical Dependency** is the pathological use or abuse of alcohol and/or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.]

**Clinical Trials** means Phase II, Phase III, and Phase IV patient research studies designated to evaluate new treatments, including prescription drugs, and that: (1) involve the treatment of life-threatening medical conditions; (2) are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives; and (3) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives. Covered clinical trials must also meet the following requirements:

1. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities; and
3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

**Coinsurance Percentage** is the applicable percentage specified in the Schedule that We will use in computing the amount payable for a benefit.

**Complications of Pregnancy** means: (1) Conditions (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, post hemorrhage, septic pelvic thromboplebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency Cesarean section required because of: (a) fetal or maternal distress during labor, (b) severe pre-eclampsia, (c) arrest of descent or dilitation, (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a Cesarean section delivery is not considered to be an emergency Cesarean section if it is merely for the convenience of the patient and/or Doctor solely due to a previous Cesarean section.

(2) Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditidiform mole; or ectopic pregnancy.

"Complications of Pregnancy" does not include false labor, occasional spotting, Doctor-prescribed rest during the period of pregnancy, morning Sickness, elective Cesarean section, and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy.

**Confined/Confinement** means the time in which a Covered Person is a Registered Bed Patient in a Hospital on the order of a Doctor, for Medically Necessary medical treatment.

**[Covered Dependent** means Eligible Dependents who have become Covered Person(s) under this Policy.]

**Covered Expenses** means: (1) Costs of treatments, services and supplies which a Doctor recommends as Medically Necessary to treat a Sickness or Injury and which in the geographical area where rendered are the Usual, Reasonable and Customary services, supplies and treatment provided for the condition being treated; (2) charges which are Usual, Reasonable and Customary and which the person incurs while he is covered; (3) charges which You or Your Covered Dependent are legally required to pay; and (4) any other charges which are identified as Covered Expenses under the Schedule of Benefits.

**Coverage Period** means the maximum length of time coverage is in force under this Policy. The Coverage Period is shown in the Schedule.

**Covered Person(s)** means You [and Your Covered Dependents]. See the provision entitled Eligibility.

**Deductible** means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. The Deductible is shown in the Schedule.

**Doctor** means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license, including a Doctor's assistant and a licensed marriage and family therapist. "Doctor" does not include You, a Covered Dependent, Immediate Family, or a Covered Person's employer.

**Effective Date** means the date coverage under the Policy begins for a Covered Person. The Effective Date is shown in the Schedule.

**Emergency Services** means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

**Policy** means the contract issued to the Policyholder providing the benefits described herein.

**Home Health Agency** means a public agency or private organization, or a sub-division of such an agency or organization, which:

1. Is primarily engaged in providing skilled nursing services and other therapeutic services;
2. Has policies established by a group of professional personnel (associated with the agency or organization), including one or more Doctors and one or more Nurses, to

govern the services which it provides, and provides for supervision of such services by a Doctor or Nurse;
3. Maintains clinical records on all patients;
4. In the case of an agency or organization in any State, in which State or applicable local law provides for the licensing of agencies or organizations of this nature:
    a. Is licensed pursuant to such law; or
    b. Is approved by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and
5. Meets such other conditions of participation as are established under the Medicare program in the interest of the health and safety of individuals who are furnished services by such agency or organization.

**Home Health Aide** means a person who (1) provides care of a medical or therapeutic nature; and (2) reports to and is directly supervised by a Home Health Agency.

**Home Health Care Plan** means a plan of home-based care which meets these standards: (1) A Doctor has established and approved the plan in writing; and (2) the plan covers a condition which would otherwise require Confinement in a Hospital or convalescent nursing home.

**Home Health Care Visit** means any visit by a member of a home health care team. Each visit by a member of the home health care team other than a Home Health Aide counts as one home health care visit. One visit up to a maximum of four hours of service by a Home Health Aide counts as one home health care visit.

**Hospital** means an institution which is legally constituted and operated in accordance with the laws pertaining to Hospitals in the Jurisdiction where it is located, which meets all of the following requirements:
1. It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
2. It provides 24-hour-a-day nursing service by a Nurse;
3. It is under the supervision of a staff of duly-licensed Doctors; and
4. It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis.

"Hospital" does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor other than incidentally, a place providing care for persons with Mental Illness or Nervous Disorders; the aged, or those suffering from alcoholism or drug addiction.

Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be Confinement in an institution other than a Hospital. A State tax-supported institution will not be excluded, even though it may not have an operating room and related equipment for surgery.

**Immediate Family** means: (1) the parent, spouse, brother, sister or children of a Covered Person (2) a resident in a Covered Person's household; or (3) any person related to a Covered Person by blood, marriage or legal adoption.

**Injury** means bodily harm caused by an accident directly and independently of Sickness or bodily infirmity resulting in unforeseen trauma requiring immediate medical attention The Injury must occur after the Covered Person's Effective Date of coverage and while such person's coverage is in force. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries, shall be considered one injury.

**Intensive Care Unit** means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board and constant observation by a Nurse or other specially-trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

**Lifetime Maximum Amount** is the total aggregate amount of benefits payable under this Policy for all Covered Expenses which are incurred for Sickness or Injury by each Covered Person during such person's lifetime, except as otherwise provided. The Lifetime Maximum Benefit applies to all Covered Expenses, unless indicated otherwise for a specific benefit, and is shown in Your Schedule.

**Medically Necessary** means that the services or supplies are provided for the diagnosis or treatment or relief of a condition, illness, injury or disease; and except as allowed under the Coverage for Clinical Trials, not for experimental, investigation, or cosmetic purposes; are necessary for and appropriate to the diagnosis or treatment and within the accepted community standards of medical care and are not solely for the convenience of the insured, the insured's family or the provider.

**[Mental Illness or Nervous Disorder** means a psychoneurosis, psychosis, eating or personality disorder or panic disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, and determined by the manifestation of symptoms regardless of whether such Mental Illness or Nervous Disorder has a physical or organic basis or origin.]

**Nurse** means a licensed registered graduate professional Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is under the direction of a Doctor. Nurse does not include the Immediate Family of a Covered Person.

**Prescription or Legend Drugs** means: (1) a Legend Drug; (2) injectable insulin prescribed by a Doctor; (3) a compounded drug of which at least one part is a Legend Drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Doctor. "Prescription or Legend Drugs" do not include oral contraceptives for prevention of pregnancy.

**Professional Review Organization** means an organization we select to provide a program of medical review services under Doctors, Nurses and record technicians.

**Registered Bed Patient** means an individual who, while Confined to a Hospital or Skilled Nursing Facility, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

**Sickness** means an Illness, disease, or infection which begins while coverage is in force under this Policy for the Covered Person. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness. Sickness includes Complications of Pregnancy. [With respect to Dependent Children who automatically become insured under the Policy at birth, the term "Sickness" shall also include medically diagnosed congenital defects and birth abnormalities.]

**Skilled Nursing Facility** means an institution, or a distinct part of an institution, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for persons convalescing from Injury or Sickness, and: (1) is approved by and is a participating Skilled Nursing Facility of Medicare; (2) has organized facilities for medical treatment and provides 24-hour a day nursing service under the full-time supervision of a licensed Doctor or Nurse; (3) maintains daily clinical records on each patient and has available

the services of a licensed Doctor under an established agreement; (4) provides appropriate methods for dispensing and administering drugs and medicines; (5) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one licensed Doctor; and (6) is not, other than incidentally, a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

**Total Disability or Totally Disabled** means that You are prevented from engaging in Your own occupation for wage or profit or any occupation to which You are suited by talent or education by reason of Injury or Sickness. [A Covered Person other than You is considered to be Totally Disabled when he is prevented by reason of Injury or Sickness from engaging in all normal activities of a person of like age and sex in good health.]

**Urgent Care Center** means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

**Usual, Reasonable and Customary** means:

1. With respect to fees or charges, fees for medical services or supplies which are:
    a. Usually charged by the provider for the service or supply given; and
    b. The average charged for the service or supply in the locality in which the service or supply is received, whichever is less; or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

**We, Us, Our or Company** means Starr Indemnity & Liability Company.

**You or Your** (also, **Policyholder**) means the primary insured person who is named in the Schedule as the Policyholder.

## ELIGIBILITY

### I. YOU

You will be eligible for insurance provided:

1. [You are at least 2 years old but under 65 years of age;
2. You are not covered as a dependent under the Policy;
3. You are not pregnant at the time of application;
4. You have a social security number (this does not apply to a minor);
5. You are not an active member of the armed forces;
6. You submit a written application for insurance, provide evidence of insurability, if evidence is required, and meet our enrollment and underwriting requirements; and
7. You pay all required premiums when due.]

### [II. ELIGIBLE DEPENDENTS

**Spouse**: You will be eligible to apply for insurance for Your lawful spouse who:

1. [Is under age 65;
2. Is not pregnant at the time of application;
3. Is not an active member of the armed forces;
4. Has a social security number; and
5. Has provided a written application for insurance and evidence of insurability, if evidence is required, has been approved, and meets our enrollment and underwriting requirements.]

**Dependent Children**: You will be eligible to apply for insurance for your dependent children who:

1. Are unmarried children primarily dependent upon You for support and maintenance; and
2. a. Are less than [19] years or age;
   b. Are at least [19] years of age but less than [25] years and enrolled and attending as a full-time student at an accredited college, university, vocational or technical school;
3. Are not pregnant at the time of application;
4. Are not active members of the armed forces; and
5. Have provided a written application for insurance and evidence of insurability, if evidence is required, have been Approved, and meet Our enrollment and underwriting requirements.

**"Children"** means natural children stepchildren, legally-adopted children, children placed with You for the purpose of adoption, children subject to Your legal guardianship, and a foster child placed in the foster home.

**"Foster child"** means a minor (i) over whom a guardian has been appointed by a court; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

**"Placement in the foster home"** means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

**"Adopted Children"** means, in connection with any adoption or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

**"Placement for adoption"** means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

If You and Your spouse are both Covered Persons, only one parent will be eligible for insurance on any Covered Dependent children You may have.**]**

### III. ENROLLMENT REQUIREMENTS

You [and Your eligible Dependents] who desire coverage must complete and submit an application for the plan and complete or provide any other documents (including evidence of insurability) as we deem necessary. You must submit the required premium with Your application form. Any misrepresentation or omission of Information in Your application or any documents submitted to Us may result in rescission of all coverage for all Covered Persons.

If You are an Insuring Parent, the Company will not deny the enrollment of a child, under this plan, because the child:

1. Was born out of wedlock;
2. Is not a dependent claimed on Your federal income tax; or
3. Does not live with You.

The Company will provide the Noninsuring Parent with claim forms and any other information needed to obtain benefits for the child. The Company will process claims and reimburse the Noninsuring Parent, provider of care, or the appropriate government agency if applicable when the Noninsuring Parent incurs an expense covered by the Policy.

**Insuring Parent** means a parent who is required by court order or administrative order to provide health insurance coverage for a child. **Noninsuring Parent** means a parent other than the Insuring Parent.

### IV. UNDERWRITING REQUIREMENTS

You [and Your Eligible Dependents] are subject to our underwriting requirements. We reserve the right to decline or rate any person at Our discretion.

### V. ADDITIONAL CONDITIONS

Insurance will not be effective unless all eligibility requirements are met and You receive written acceptance from Us. Insurance on a Covered Person will not be effective unless premium is paid and accepted by Us for such insurance. Issuance of a Policy is not a waiver of any of the above conditions.

## EFFECTIVE DATES

### I. YOU [AND ELIGIBLE DEPENDENTS]

[Coverage is effective as of the Effective Date for You [and any Eligible Dependents] who were included in Your initial application, provided that You meet Our eligibility, underwriting and enrollment requirements. Coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "Yes" to any of the medical history questions in the Application. If such person is the Applicant, coverage is automatically declined for all persons included in Your Application].

### [II. NEWLY ACQUIRED DEPENDENT CHILDREN

Coverage for your child or children born after the Effective Date of this Policy will be effective from the moment of birth. Coverage for that child will end 90 days after this automatic Effective Date unless you have made a written request directing us to add the child or children to your coverage. We must receive this notice within 90 days after the child's date of birth.

Coverage for a child whom a petition for adoption ahs been filed, will become effective the the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if coverage is applied for within the 60-days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption.

Any required additional premium must accompany Your notice. A claim form or Hospital bill does not constitute written notice.

Coverage for your child or children will be for Injury or Sickness, including congenital defects, premature birth and tests for hypothyroidism, phenylketonuria, galactosemia, and sickle-cell anemia for a non-Caucasian newborn child. ]

## TERMINATION OF INSURANCE

### I. TERMINATION OF YOUR INSURANCE

Your insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due, if such payment has not been made within 31-days following such premium due date;
2. The [date] [the first day of any policy month] [the anniversary of any premium due date] that insurance under the Policy is discontinued provided the Policyholder received [30-60] day advance written notice;
3. The date that We determine fraudulent statements or a material misrepresentation has been made by You or with Your knowledge in filing a claim for benefits;
4. The date that You enter full-time active duty in the armed forces of any country or international organization;
5. The date You become eligible for Medicare;
6. The earlier of: (1) the Expiration Date of Your coverage; or (2) 12-months from the

Effective Date of Your insurance, whichever occurs first.

**[II. TERMINATION OF A COVERED DEPENDENT'S INSURANCE**

A Covered Dependent's insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due if such premium payment has not been made within 31-days following such premium due date;
2. The [date] [the first day of any policy month] [the anniversary of any premium due date] that insurance under the Policy is discontinued provided the Policyholder received [30-60] day advance written notice;
3. The date that we determine fraud or material misrepresentation has been made by You or a Covered Dependent or with Your or a Covered Dependent's knowledge in filing a claim for benefits;
4. The date that Your insurance terminates. However, if termination is due to Your death, a Covered Dependent may elect to continue coverage beyond the original Expiration Date by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, Your Covered Dependent spouse will be considered the primary insured;
5. The date You or a Covered Dependent becomes eligible for Medicare;
6. The date the Covered Dependent ceases to be eligible. However if, upon attaining any limiting age, a Covered Dependent has a handicapped condition rendering such person incapable of earning his own living and is chiefly dependent upon You or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the limiting age, benefits with respect to such person may be continued on a premium-paying basis during the continuance of such dependency. During the first 2-years that insurance is being continued, we have the right to have the dependent examined at any time by Doctors designated by us. Thereafter, we will not require examination more than once each year. The continuance of insurance as described will cease in the event of:
    a. The termination of the Policy; or
    b. The termination of Your insurance; or
    c. The discontinuance of insurance under the Policy; or
8. The earlier of (i) the Expiration Date shown in the Schedule; or (ii) [12-months] from the Effective Date of Your insurance, whichever occurs first. ]

**III. Termination of the Policy:** The Policy will terminate on the earliest of the following dates:

1. The date the Policyholder elects to terminate the Policy, provided that the Policyholder gives us at least [60 days] advance written notice; or
2. The date there are no Covered Persons under the Policy.

We may terminate the Policy on [the first day of any policy month] [the anniversary of any premium due date] by giving the Policyholder at least [30 days] advance written notice.

**HOSPITAL PRECERTIFICATION**

Hospital admissions and lengths of stay are subject to certification by a Professional Review Organization, as stated below:

1. You must notify the Professional Review Organization on behalf of a Covered Person:
    a. Ten (10) days prior to non-emergency admission of the Covered Person to a Hospital;
    b. Within 48-hours from the time the Covered Person is in stable condition following an emergency admission*, or as soon thereafter as is reasonably possible if the Covered Person's medical condition prevents or delays such notification; or
    c. Within 48-hours of normal delivery (96 hours for cesarean section) for complicated birth or as soon as reasonably possible.

*A person is covered for Emergency Medical Conditions and may receive medical services to treat an Emergency Medical Condition without prior authorization if a prudent layperson acting reasonably would have believed that an Emergency Medical Condition existed. In order to ensure that a person receives proper care for their condition, the person should call the Professional Review Organization and inform them of their condition and the services they are receiving.

When prior authorization has been given for Emergency Services, the Company will cover the services and will not retract the authorization after the services have been provided unless the authorization was based on material misrepresentation about the Covered Person's health condition.

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic condition that would lead a prudent layperson possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any body organ or part.

2. The Professional Review Organization, after reviewing the applicable information, will certify:
   a. If the Hospital admission is Medically Necessary;
   b. The appropriate length of stay; and
   c. Appropriate extensions beyond the initially-certified length of stay.

3. **REDUCTION OF BENEFITS:** If Covered Expenses for the Hospital admission, length of stay, or extensions of stay are not certified by the Professional Review Organization, We will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. No benefits will be payable in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary.

## DESCRIPTION OF BENEFITS

### I. WHAT IS COVERED

Subject to the Hospital Precertification provision, if You [or a Covered Dependent] incurs Covered Expenses for medical treatment supplies or services as a result of a Sickness or Injury which occurs while coverage is in force, and after satisfaction of the Deductible, We will pay the Coinsurance Percentage for Covered Expenses incurred in excess of the Deductible. We will pay this amount for all Covered Expenses unless otherwise noted for a specific benefit or specified as limited or excluded in the Limitations and Exclusions provision.

After Covered Expenses for which benefits are payable at the Coinsurance Percentage have equaled the Coinsurance Limit for a Covered Person, We will pay Covered Expenses in excess of the Coinsurance Limit at the amount shown in the Schedule for each such person while coverage is in force, but not to exceed the Lifetime Maximum Amount payable for each Covered Person.

The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount are shown in Section I of the Schedule and apply to each Covered Person and for all benefits, unless otherwise stated for a specific benefit in Section II of the Schedule.

## II. COVERED EXPENSES

**Covered Expenses** mean the Usual, Reasonable and Customary charges for the following Medically Necessary services, supplies, or treatment prescribed or provided by a Doctor for a covered Injury or Sickness while coverage is in force for a Covered Person. The Company reserves the right to interpret and determine coverage for Covered Expenses. The fact that a Doctor has prescribed, recommended, approved, or provided a treatment, service or supply does not, in itself, make such treatment, service or supply a Medically Necessary covered expense.

### A) HOSPITAL COVERED EXPENSES

1. **Hospital Room, Board and General Nursing Care:** While Confined in a Hospital, the Coinsurance Percentage for the average daily charge for room and board in a semiprivate room with at least two beds. If the Hospital does not have semiprivate rooms available, the Coinsurance percentage will be based on the daily charge for room and board for the Hospital's lowest rate private room. If a facility contains only private rooms, coverage will be limited to the Coinsurance Percentage shown in the Schedule for a private room.

2. **Intensive or Specialized Care Unit:** Provided four or more hours of nursing care is being provided each day, the Coinsurance Percentage for each day of Confinement, up to 3 times the average semi-private room rate. If the Hospital does not have semiprivate rooms available, the amount payable will be 3 times the daily charge for room and board at the Hospital's lowest rate private room.

3. **Emergency Room Treatment**: The Coinsurance percentage for services, supplies and treatment.

4. **Miscellaneous Medical Services:** The Coinsurance Percentage for services and supplies provided on an inpatient basis in a Hospital. Miscellaneous charges do not include charges for a telephone, radio, television, extra beds or cots, meals for guests, take home items, or other items of convenience.

5. **Outpatient Hospital Services:** The Coinsurance Percentage for charges made by a Hospital when received on an outpatient basis, excluding professional services.

### B) COVERED EXPENSES FOR TREATMENT

1. **Doctor Services:** The Coinsurance Percentage for treatment provided by a Doctor. This benefit is not payable for treatment provided by a member of your Immediate Family.

2. **Therapist Services:** The Coinsurance Percentage for treatment provided by a therapist for diagnosis and rehabilitative treatment. This benefit is not payable for treatment provided by a member of your immediate family.

### C) OTHER COVERED EXPENSES

1. **Ambulatory Surgical Center [or Outpatient Hospital Surgery]:** The Coinsurance Percentage for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital [or a Hospital Outpatient Surgery Facility].

2. **Anesthetics:** The Coinsurance Percentage of the amount payable to the Doctor performing the surgery for anesthetics and their administration. The Coinsurance Percentage specific to this benefit is shown in the Schedule. This includes coverage for payment of anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

3. **Assistant Surgeon:** The Coinsurance Percentage of the amount payable to the Doctor performing the surgery for a Doctor assisting in the performance of a surgery. The Coinsurance Percentage specific to this benefit is shown in the Schedule.

4. **Surgeon's Assistant:** The Coinsurance Percentage of the amount payable to the Doctor performing the surgery for a Doctor assisting such Doctor. The Coinsurance Percentage specific to this benefit is shown in the Schedule.

5. **Blood or Blood Plasma:** The Coinsurance Percentage, if not replaced.

6. **Artificial Limbs or Eyes:** The Coinsurance Percentage.

7. **Casts, Non-Dental Splints, Trusses, Crutches, or Non-Orthodontic Braces:** The Coinsurance Percentage.

8. **Equipment Rental:** The Coinsurance Percentage for a wheelchair, hospital-type bed or similar durable medical equipment, not to exceed the purchase price of such equipment.

9. **Oxygen:** The Coinsurance Percentage for oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment.

10. **Complications of Pregnancy:** Treatment for Complications of Pregnancy on the same basis as any other Sickness.

11. **X-Ray and Laboratory Tests:** The Coinsurance Percentage for X-Ray and laboratory on an outpatient basis.

12. **[Prescription or Legend Drugs:** The Coinsurance Percentage when prescribed on an inpatient basis for a Covered Injury or Sickness.]

13. **Dental Treatment:** The Coinsurance Percentage for treatment or care required as a result of a Covered Injury to a tooth that is natural, free of disease, and vital where the major portion of the tooth is present regardless of fillings or caps.

14. **[Cosmetic or Reconstructive Surgery (Except Breast Reconstructive Surgery):** The Coinsurance Percentage for cosmetic or reconstructive surgery and complications of cosmetic procedures when services and treatment are:

    a. Incidental to or follows a Covered Injury or Sickness occurring while this coverage is in force; or

    b. Performed due to a congenital defect or birth anomaly of a Covered Person born while this coverage is in force, including but not limited to the necessary care and treatment needed for individuals born with a cleft lip and cleft palate, of a newborn child, foster child or adopted child.]

15. **Breast Reconstructive Surgery:** The Coinsurance Percentage for a female Covered Person who undergoes a covered mastectomy surgery while such person's coverage under this Policy is in force. Benefits payable include:

    a. Reconstructive surgery of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast for the purpose of obtaining a symmetrical appearance; and

    c. Prostheses and for treatment for physical complications related to the mastectomy.

16. **Mammography:** The Coinsurance Percentage for low-dose screening mammography as follows, not to exceed the Maximum Benefit Amount shown in the Schedule:

    a. One or more mammograms a year, as recommended by a Doctor, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

        i. The woman has a personal history of breast cancer;

        ii. The woman has a personal history of biopsy-proven benign breast disease;

        iii. The woman's mother, sister, or daughter has or has had breast cancer; or

        iv. The woman has not given birth prior to age 30;

    b. One baseline mammogram for any woman 35 through 39 years of age, inclusive;

    c. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Doctor; and

    d. A mammogram every year for any woman 50 years of age or older.

    e. diagnostic mammography at any age when prescribed by the woman's Doctor.

    Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's Doctor.

    "Diagnostic mammography" means a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the Doctor interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Doctor to correlate the radiologic findings is often performed as part of the study.

    These charges are [not] subject to the Deductible.

17. **Clinical Trials:** Charges for participation in Phase II, Phase III, and Phase IV-covered Clinical Trials who meet protocol requirements of the trials and provide informed consent. Only Medically Necessary costs associated with participation in a covered clinical trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and

medically necessary monitoring will be covered and only to the extent that such costs have not been or are not funded by the national agencies, commercial manufacturers, distributors, or other research sponsors of participants in Clinical Trials. This provision will not cover: (a) non-FDA approved drugs provided or made available to an insured who received the drug during a covered clinical trial after the clinical trial has been discontinued; (b) services that are not health care services; (c) services provided solely to satisfy data collection and analysis needs; (d) services related to investigational drugs and devices; and (e) services that are not provided for the direct clinical management of the patient. The Company can deny any claim where covered services under this provision and non-covered services are not separated.

18. **Temporomandibular:** The Coinsurance Percentage for procedures involving any bone or joint of the jaw, face, or head, so long as the procedure is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic Injury. Authorized therapeutic procedures include splinting and the use of intraoral prosthetic applies to reposition the bones. However, this does not include coverage for orthodontic braces, crowns, dentures, treatment for periodontal disease, dental root form implants or root canals.

19. **Diabetic Benefit:** The Coinsurance Percentage for medical coverage for Medically Necessary equipment, supplies, and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a Doctor.

    Self-management training shall include coverage for one (1) per lifetime training program per insured for diabetes self-management training when Medically Necessary as determined by a Doctor and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training. In addition to the one (1) lifetime training program, additional diabetes self-management training may be provided in the event that a Doctor prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the insured's symptoms or conditions. A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a Doctor.

    Diabetes Self-Management Training means instruction in an inpatient or outpatient setting, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs which the primary purpose is weight reduction, when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association.

20. **Ambulance:** Up to the Maximum Benefit amount shown in the Schedule for this benefit for local licensed ground ambulance service or air ambulance service within the 48 contiguous states to the nearest Hospital qualified to treat the covered Injury or Sickness. Such service must be Medically Necessary due to a sudden and unexpected Injury or Sickness that involves a life-threatening element.

21. **Routine Child Health Care:** The Coinsurance Percentage for 20 visits at the approximate age intervals of: birth; 2 weeks; 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months; 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years, that include a history, a physical examination, a development assessment, anticipatory guidance and appropriate immunizations and laboratory tests consistent with the Recommendations of Preventative Pediatric Health Care of the American Academy of Pediatrics from the moment of birth to age 18. These charges, with the exception of immunizations, are subject to the Deductible.

22. **[Organ or Tissue Transplants:** The Coinsurance Percentage for an organ or tissue transplant, up to the Lifetime Maximum Amount shown in the Schedule for this benefit. This benefit shall include all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, including the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

    Covered Expenses do not include organ or tissue transplants which:

    a. Are animal-to-human transplants;

    b. Use artificial or mechanical organs;

    c. Are Experimental or Investigative; or

    d. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness].

23. **Home Health Care:** Charges for home health care, up to the Maximum Benefit Amount and for the Maximum Benefit Period shown in the Schedule for this benefit, for the following:

    a. Part-time or intermittent home nursing care by, or under the direction of, a graduate registered Nurse (RN);

    b. Part-time or intermittent Home Health Aide services that consist only of care for the Covered Person and which are Medically Necessary, as part of the Home Health Care Plan. The services must be under the direction of a Nurse or social worker;

    c. Physical, respiratory, occupational, or speech therapy performed by a licensed therapist for rehabilitative treatment;

    d. Nutrition counseling provided by or under the direction of a registered dietician as part of the Home Health Care Plan; or

    e. The evaluation of the need for and development of a plan by a Doctor, Nurse or social worker. Such services must be requested by the Doctor and approved by us. Review of Medical Necessity may be periodically required.

24. **Skilled Nursing Facility Confinement:** Daily charges for room and board while a Covered Person is confined as a registered bed patient in the facility. The Maximum Benefit Amount and Maximum Days for this benefit are shown in the Schedule. Such Confinement must: (i) start within 14 days after the end of a covered Hospital Confinement of at least 3 continuous days; and (ii) be ordered by a Doctor to convalesce from an Injury or Sickness that caused the prior Hospital Confinement.

25. **Hospice Care:** Hospice care and services incurred for a terminally ill Covered Person with a life expectancy of 6 months or less, up to the Maximum Benefit Amount shown in the Schedule for this benefit. Covered Expenses include charges incurred for care and services when provided by an agency licensed or certified to provide hospice services, including the following:

    a. Part-time or intermittent home nursing care by, or under the direction of a Nurse;

    b. Physical, respiratory or speech therapy performed by a licensed therapist;

    c. Nutrition counseling provided by or under the direction of a registered dietitian; and

    d. Counseling by a licensed social worker, pastoral counselor for the Covered Person or a member of the Immediate Family, the primary care giver and individuals with significant personal ties to a Covered Person who is terminally ill.

    Hospice services must be:

    a. Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and

    b. Provided only if the Doctor submits written certification to Us that the Covered Person is terminally ill with a life expectancy of 6 months or less. Review of Medically Necessity may be periodically required.

    This benefit does not include the services of volunteers or persons who do not regularly charge for their services.

26. **AIDS:** The Coinsurance Percentage for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or any complication or condition caused by, resulting from or related to AIDS or HIV, up to the Lifetime Maximum Amount shown in the Schedule for this benefit.

27. **[Foreign Travel:** After satisfying the Deductible specific to this benefit, We will pay the Coinsurance Percentage for medical care while in a foreign country, up to the Lifetime Maximum Amount shown in the Schedule for this benefit. The Covered Person's primary residence must be in the United States and treatment rendered for an Injury or the sudden and unexpected onset of a Sickness requiring immediate medical attention and be provided within [the first 90 days] of the Covered Person's trip outside the United States. The Deductible for this benefit is shown in the Schedule**]**.

28. **[Knee Injury or Disorder**: The Coinsurance Percentage payable for the treatment of Knee Injury or disorder. This does not include charges incurred to diagnose or treat an Injury or disorder of the knee including surgery in excess of the Knee Injury or Disorder Maximum shown in the Schedule. The knee consists of the bones, muscles, cartilage, ligaments, membranes and menisci of the anterior aspect of the leg at the articulation of the femur and tibia.]

29. **[Gallbladder Surgery**: The Coinsurance Percentage for surgery for cholecystectomy and any type of surgical procedure to diagnose or treat a disorder of the gallbladder, including any condition related to or caused by a gallstone(s) in the bile duct. Surgery includes the pre-operative and post-operative visits, testing, the services of the surgeon, assistance surgeon,

anesthesiologist, radiologist, pathologist, the Hospital or outpatient facility charges, and any other charges related to the surgery or complications therefrom. Expenses do not include charges incurred in excess of the Gallbladder Surgery Maximum shown in the Schedule. ]

30. **Loss or Impairment of Speech or Hearing:** The Coinsurance Percentage for the Medically Necessary diagnosis and treatment of loss or impairment of speech or hearing. Covered Expenses for such treatment will be paid as they would for any other Sickness. No benefits will be paid for hearing instruments or devices. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

31. **Colorectal Cancer Exams and Lab Tests:** The Coinsurance Percentage for the following colorectal cancer examinations and laboratory tests: (1) an annual fecal ocular blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; (2) a double-contrast barium enema every five years; (3) a colonoscopy every ten years; and (4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, subject to the guidelines for the management or subsequent need for follow-up colonoscopy.

    These benefits will be covered for a Covered Person who is: (1) fifty years of age or older; (2) less than fifty years of age and a high risk for colorectal cancer according to the current American Cancer Society colorectal cancer screening guidelines; and (3) experiencing the following symptoms of colorectal cancer as determined by a Doctor: (a) bleeding from the rectum or blood in the stool; or (b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

32. **Medically Necessary Foods:** The Coinsurance Percentage for medical foods and low protein modified food products for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if:
    a. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
    b. The products are administered under the direction of a Doctor;
    c. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars ($2,400) per year per person allowed under Arkansas law.

    This includes coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a Doctor for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

33. **Prostate Cancer Screening**: The Coinsurance Percentage for screening for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines and performed by a qualified medical professional. If a medical practitioner recommends that an insured, undergo a prostate specific antigen blood test, coverage may not be denied on the ground that the insured has already had a

digital rectal examination and the examination result was negative. These charges are not subject to the Deductible.

34. **[Hearing Aids**: The Coinsurance Percentage for coverage for a hearing aid or hearing instrument sold by a professional licensed by the state to dispense a hearing aid or hearing instrument, not to exceed one thousand four hundred dollars ($1,400) per beginning on the first day of coverage. These charges are not subject to the deductibles or any copayment requirements.]

35. **In Vitro Fertilization**: The Coinsurance Percentage for in vitro fertilization services performed at a medical facility certified by the Department of Health, or a facility certified as conforming to the American College of Obstetricians and Gynecologists Guidelines for In Vitro Fertilization, or which meets the American Fertility Society standards.

36. **Hospital Newborn Coverage:** The Coinsurance Percentage for routine nursery care and pediatric charges for up to five (5) full days in a Hospital nursery or until discharge of the mother of the newborn from the Hospital following the birth of the child, whichever is the later; and any testing of a newborn child hereafter mandated by law.

## III. ALLOCATION AND APPORTIONMENT OF BENEFITS

We reserve the right to allocate the Deductible to any Covered Expenses and to apportion the payment of benefits between You and any person designated by You. Such allocation and apportionment shall be conclusive and shall be binding upon You and all assignees.

## IV. EXTENSION OF COVERAGE

If You [or Your Covered Dependent] [is][are] Totally Disabled and receiving benefits for a Hospital Confinement on the date that this Policy terminates [or such dependents coverage under this Policy terminates], benefits will continue in accordance with the terms of this Policy for as long as that Confinement remains continuous and You [or Your Covered Dependent] [is][are] Totally Disabled by reason of such Injury or Sickness. However, in no event will coverage continue beyond the end of the [60 days] following the date coverage ends or the Expiration Date of the Covered Person's coverage. Benefits payable after the Expiration Date or when a Covered Person's coverage ends are subject to a new Deductible and satisfaction of the Coinsurance Limit.

## LIMITATIONS AND EXCLUSIONS

We will not pay for loss or expense caused by or resulting from any of the following:

1. [Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision;]
2. [Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated. except in accordance with the Extension of Benefits provision;]
3. [Expenses to treat complications resulting from treatment of conditions which are not covered under the Policy. This does not include Emergency Services as defined;]
4. [Experimental or Investigative services or treatment. "Experimental or Investigative" means services, supplies, devices, treatments, procedures, or drugs that have no been recognized as generally accepted medical treatments. Our determination of what constitutes Experimental or Investigative treatment will be based on, but not limited to, the approval of treatments from the American Medical Association, the U.S. Food and

Drug Administration, and the Administrative Procedure Act. Experimental or Investigative includes treatments that have not been demonstrated through sufficient peer-reviewed medical literature to be safe and effective for the proposed use;]

5. [Expenses for purposes determined by Us to be educational, except when specifically covered;]
6. [Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies;]
7. [Expenses You [or Your Covered Dependent] are not required to pay, or which would not have been billed, if no insurance existed;]
8. [Expenses to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan;]
9. [Charges that are eligible for payment by Medicare or any other government program except Medicaid;]
10. [Costs for care in government institutions unless You [or Your Covered Dependent] are obligated to pay for such care;]
11. [Expenses for the treatment of an occupational Injury or Sickness which are paid under any Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under any Workers' Compensation ;]
12. [Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited);]
13. [Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to You on a pro rated basis;]
14. [Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;]
15. [Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault;]
16. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy;
17. [Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital except as specifically covered under the Policy, This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth;]
18. [Charges for voluntary termination of normal pregnancy, normal childbirth or elective cesarean section;]
19. [The cost of any drug, including birth control pills, supply, treatment or procedure that prevents conception or childbirth;]
20. [Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate;]
21. [Expenses for sterilization or reversal of sterilization;]
22. [Services, supplies or treatment related to sex transformation or sex dysfunction or inadequacies;]
23. [Costs for physical exams or other services not needed for medical treatment, except as specifically covered;]

24. [Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered;]
25. [Expenses for the treatment of Mental Illness or Nervous Disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind, unless specifically covered;]
26. [The costs of treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction, unless specifically covered;]
27. [Expenses incurred in the treatment of Injury or Sickness sustained by voluntary use of alcohol, illegal drugs or hallucinogenics;]
28. [The cost of programs, treatment, or procedures for tobacco use cessation;]
29. [Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, whether while sane or insane;]
30. [The cost of dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered;]
31. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, except as specifically covered;
32. [Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to asses the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts;]
33. [The costs for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids except as specifically covered;]
34. [The costs of cosmetic or reconstructive procedures, services or supplies, except as specifically covered;]
35. [Charges for breast reduction or augmentation or complications arising from these procedures;]
36. Outpatient Prescription or Legend Drugs, medications, vitamins and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor;
37. [The cost of any drug or other item used to treat hair loss;]
38. [Expenses incurred in the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person;]
39. [Expenses incurred in the treatment of acne or varicose veins;]
40. [The costs of weight loss programs, diets, or treatment of obesity;]
41. [Transportation charges, except as specifically covered;]
42. [Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital, unless specifically covered;]
43. [Costs of services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the

skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops, except as specifically covered;]

44. [Costs of services or supplies furnished or provided by a member of Your Immediate Family;]
45. [Expenses for diagnosis or treatment of a sleeping disorder;]
46. [Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests;]
47. [Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator);]
48. [The costs of services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits;]
49. [Expenses for surgery during the first 6 months after the Effective Date of Coverage for a Covered Person for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis or carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-Existing Conditions exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, herniorraphy, or cholecystectomies;]
50. [Knee Injury or Disorder: Expenses do not include charges incurred to diagnose or treat an Injury or disorder of the knee including surgery in excess of the Knee Injury or Disorder Maximum shown in the schedule;]
51. [Gallbladder Surgery: Expenses do not include charges incurred in excess of the Gallbladder Surgery Maximum shown in the Schedule;]
52. [Participating in [Interscholastic] [Intercollegiate] [Organized Competitive] Sports;
53. [Medical care, treatment, services, or supplies received outside of the United States or its possessions;]

## PRE-EXISTING CONDITIONS LIMITATION

We will not provide benefits for any loss caused by or resulting from, a Pre-Existing Condition.

**"Pre-Existing Conditions"** mean any medical condition or Sickness for which medical advice, care, diagnosis, treatment, consultation, or medication was recommended by or received from a Doctor within the [24 months - 5 years] immediately prior to a Covered Person's Effective Date of Coverage. [This does not apply to congenital birth defects or anomalies of newborn infants, foster children and adopted children when you have paid the additional premium within 30 days of acquiring such dependent.]

**"Consultation"** means evaluation, diagnosis or medical advice was given with or without the necessity of a personal examination or visit.

## CLAIM PROVISIONS

**Notice of Claim:** When a claim arises, the claimant should notify Us or Our authorized administrator or Our authorized agent of the Loss in writing. This written notice of claim must be given within [20] days after commencement of any Loss, or as soon as reasonably possible.

**Claim Forms**: After receiving notice of claim, We or Our authorized administrator will furnish the claimant with a claim form for filing proof of Loss. If this form is not received within [15 days] after notice has been given, the claimant should submit written proof which covers the occurrence, the character, and the extent of the Loss for which claim is made.

**Proof of Loss:** The claimant must furnish Us or Our authorized administrator with written proof of Loss within [180 days] of the Loss. Where this Policy provides for payments contingent upon a period of Confinement, these [180 days] shall begin at the end of the period for which We are liable. If the claimant does not furnish proof within [180 days] as required, benefits shall still be paid for that loss if: (1) it was not reasonably possible to give proof within those [180 days]; and (2) proof is furnished as soon as reasonably possible and, except in the absence of legal capacity no later than 1 year after the end of those [180 days].

**Time of Payment of Claims:** We will make payment within 30 days upon receipt of due written proof of loss.

**Payment of Claims:** Payment will be made directly to You or the provider of the service, as directed by You in writing at the time of submitting proof of Loss. If You are deceased or, in Our opinion, are Incapable of giving a valid receipt for payment and if no claim has been made by a duly-appointed legal representative, We shall have the option of making payment to either: (1) the Hospital or the person who actually incurred the loss for which payment is due; or (2) Your surviving relative. Such a payment shall discharge Us from all further liability to the extent of the payment made. If any payment payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay an amount not exceeding [$3,000] to any relative by blood or connection by marriage of the Insured or beneficiary deemed to be equitably entitled. Such a payment shall discharge the Company for all further liability to the extent of the payment made.

**Appeal of Claim Denial:** If a claim is denied, You will receive written notice giving the reason for the denial. If You wish to appeal the denial of the claim, such appeal must be submitted to us in writing within [60 days] from the date of notice. You must clearly state the reason You believe the claim decision is incorrect.

**Right of Reimbursement:** If a Covered Person receives a benefit payment from a third party by judgment, settlement, compromise, or otherwise for an Injury or Sickness and we have paid benefits for the same Injury or Sickness, we reserve the right to be reimbursed from the third party in an amount equal to the amount we paid to the Covered Person, the Covered Person's parents (if the Covered Person is a minor), or the Covered Person's legal representative.

You must agree to furnish any information and assistance, or provide any documents that we may reasonably require in order for us to exercise our right of recovery, regardless of whether or not the third party admits liability, Any payment we make by mistake for a work-related Injury must be reimbursed to us when the Covered Person receives payment for such Injury from another source.

It will be assumed that the Covered Person is in receipt of the benefit payment unless such person gives us proof that payment of benefits was denied.

## GENERAL PROVISIONS

**Amendment:** We may amend or change the Policy at any time by giving written notification to the Policyholder. Insurance provided by the Policy may be amended changed or canceled without the consent of any Covered Person.

**[Arbitration:** If You have any disputes with Us or Our authorized administrator regarding coverage or claim, You have the right to seek arbitration to settle the issue. The proceeding is voluntary, but both You and Us (or Our administrator) must mutually agree to the arbitration proceeding. Arbitration will provide a fair and impartial ruling, free of any conflicts of interest and will be conducted according to the rules of the American Arbitration Association and in accordance with the Uniform Arbitration Act. The decision of the arbitrator may be binding on both parties, or non-binding upon the insured.

Arbitration in no way affects Your right to: (i) file a complaint with the Department of Insurance in connection with a claim or any other dispute; or (ii) take legal action in a court of law, **prior to voluntarily agreeing to enter into an arbitration proceeding.**

However, by voluntarily agreeing to enter into an arbitration proceeding, You should be aware and understand that You may be giving up certain rights to have Your dispute settled in and by a court of law, unless the law in Your state provides for judicial review of arbitration proceedings. This does not prohibit a Covered Person from seeking a decision from a jury trial if they are not in agreement with the decision reached in arbitration.]

**Assignment and Claims of Creditors:** Except as provided below, benefits are not assignable. Except as otherwise provided by law, benefit payments may be exempt from legal process for debts or liabilities of a Covered Person. You may direct us to pay benefits to the person or institution on whose charges any claim is based. Any such payment that We make will fully discharge Us to the extent of the payment.

**Changes in Benefits:** Changes in the benefits of a Covered Person will apply only to Covered Expenses or losses incurred after the effective date of the change.

**Clerical Error:** Clerical errors that We or Our authorized administrator make in Your Schedule of benefits, the issuance of a Policy, or in record keeping will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to offset or recover from You any overpayment of benefits made due to such errors.

**Conformity With Statutes:** Any provision of this Policy that is in conflict with the statutes of the jurisdiction in which the Policyholder is located on such date is hereby amended to conform to the minimum requirements of such statutes.

**Contract/Changes:** The effective time for any dates used shall be 12:01 A M. Standard Time at the address of the Policyholder.

**Entire Contract:** The entire contract consists of the Policy, Your application form and any other documents requested and accepted by Us. No change in the Policy or Your coverage is valid unless approved by Our Executive Officer. Such approval must be signed by Our Executive Officer and attached to the Policy. No broker, agent or producer can change or waive any provision of the entire contract or any of Our requirements.

**Grace Period:** You have a 31-day Grace Period for the payment of each premium due after the first premium. Your coverage will continue in force during the Grace Period unless You have given Us prior written notice of termination. If such a premium is not paid by the end of the Grace Period, all such insurance will end as of the due date of such premiums, and no expenses incurred during the Grace Period will be considered for benefits.

**Incontestability:** All statements You make will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest unless You have been given a copy. Any misstatement or omission of information made on Your application form or on any other materials on which We relied to issue, change or

increase coverage will be considered a misrepresentation and may be the basis for later rescission of coverage. After coverage for a Covered Person has been in force for 3 years during the Covered Person's lifetime, We do not have the right to contest coverage, except for fraud or non-payment of premium.

**Legal Proceedings:** No proceedings to obtain benefits may be brought against Us until 60 days after We have received proper written proof of Loss and any other documentation necessary to establish the benefits due. No proceedings may be brought more than 3 years after proof is required to be filed.

**Physical Exam and Autopsy:** We may require, at Our expense, medical examinations of any person for whom claim is made when and as often as it may reasonably require during the pendency of a claim. [We may also make an autopsy. if not forbidden by law].

**Premium Payments:** All premiums are paid to Us, or, if We direct, to Our authorized administrator. The first premium is due on the Effective Date. Subsequent premiums are due [monthly], in advance, on the anniversary day and month of the Effective Date. Except as otherwise provided herein, all such insurance will terminate on the premium due date, except as provided in the Grace Period provision, if premiums are not paid when due.

**Premium Changes:** We will determine the premium for each Covered Person. We have the right to change premium rates on any premium due date by giving You [45 days] advance written notice of such change. The premium rates will not be changed more often than once every [6] months after the first Policy anniversary date.

**Pronouns:** Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also unless the context clearly indicates to the contrary.

**Rescission:** A misrepresentation or omission in the application form or other documents provided to Us may be the basis for later rescission of all coverage of all persons covered under the Policy. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims We paid.

**Workers' Compensation:** This Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

**Misstatement of Age:** If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

**Reinstatement:** If any renewal premium is not paid within the time granted the Covered Person for payment, a subsequent acceptance of premium by the Company without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

**Refund of unearned premiums upon death of insured.** Upon the death of the Covered Person, the proceeds payable to the insured or his or her estate under the Policy shall include premiums paid for any period beyond the end of the Policy month in which the death occurred. The unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the Covered Person's death has been furnished to the Company.